DEPARTMENT OF HEALTH & HUMAN SERVICES

National Medicare

TRAINING PROGRAM

CENTERS FOR MEDICARE & MEDICARD SERVICES

Understanding Medicare Module 1



...helping people with Medicare make informed health care decisions



Centers for Medicare & Medicaid Services National Train-the-Trainer Workshops Instructor Information Sheet Module 1: Understanding Medicare

Module Description

Original Medicare, Medicare Advantage and Other Medicare Health Plans, and Medicare Prescription Drug Coverage are choices in the Medicare program. This module provides the Medicare "basics" - what Medicare is, your Medicare coverage options, Medicare eligibility, your rights, and how to enroll.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers familiar with the Medicare program, who would like to have prepared information for their presentations.

The following sections are included in this module:

| to no wing sections are included in this module. | | | |
|--------------------------------------------------|-------------------------------------------------------|--|--|
| Slides | Topics | | |
| 2 | Objectives | | |
| 4-40 | Program Basics | | |
| 41-86 | Medicare Coverage Choices | | |
| 87-97 | Rights and the Appeals Process | | |
| 98-103 | Programs for People with Limited Income and Resources | | |
| 104 | Information Resources | | |

Objectives

- Recognize the parts of Medicare
- Compare Medicare coverage options
- Relate Medicare-covered services and supplies
- Recognize Medicare rights and appeals
- Explain programs for people with limited income and resources

Target Audience

This comprehensive module is designed for presentation to trainers and other information givers.

Learning Activities

This module contains seven interactive learning questions that give participants the opportunity to apply the module concepts in a real-world setting.

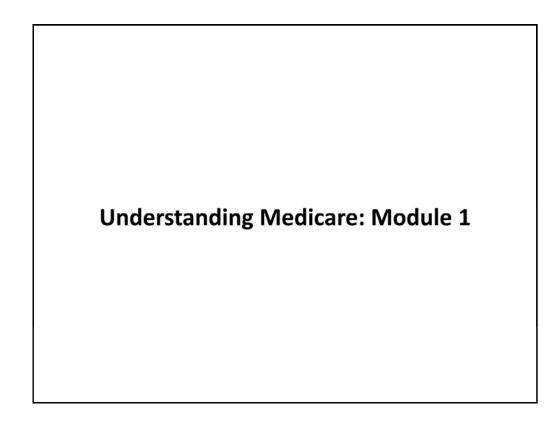
Handouts

Slide 49 is provided as full page handouts as Appendix A. Appendix B is a job aid regarding the new Medicare Advantage Disenrollment Period. Appendix C is a chart of Medicare Part D standard coverage and the Low Income Subsidy copayments. Appendix D is the Medicare appeals chart. You may want to refer to these during your training if you provide copies of the workbooks to attendees. Or, you may wish to make copies of the handouts and distribute them as learning aids.

Time Considerations

The module consists of 105 PowerPoint slides with corresponding speaker's notes. It can be presented in about 2½ hours – 3 hours. Allow approximately 30 more minutes for discussion, questions and answers.

References - See slide 104



Module 1 *Understanding Medicare* explains basics of Medicare, Medigap, and programs to help people with limited income and resources.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The information in this module was correct as of April 2011.



To check for updates on the new health care legislation, visit www.healthcare.gov.

To view the Affordable Care Act visit



www.healthcare.gov/center/authorities/patient_protection_affordable_care_act_as_passed.pdf



To check for an updated version of this training module, visit www.cms.gov/NationalMedicareTrainingProgram/TL/list.asp on the web.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Session Objectives

This session will help you to

- Recognize the parts of Medicare
- Compare Medicare coverage options
- Relate Medicare-covered services and supplies
- Recognize Medicare rights and appeals
- Explain programs for people with limited income and resources

04/28/2011

Understanding Medicare

- This session will help you to
 - Recognize the parts of Medicare
 - Compare Medicare coverage options
 - Relate Medicare-covered services and supplies
 - Recognize Medicare rights and appeals
 - Explain programs for people with limited income and resources

Understanding Medicare – Lessons

- 1. Program Basics
- 2. Medicare Coverage Choices
- 3. Rights and the Appeals Process
- 4. Programs for People with Limited Income and Resources

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Understanding Medicare

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Understanding Medicare is divided into five lessons.

- 1. Program Basics
- 2. Medicare Coverage Choices
- 3. Rights and the Appeals Process
- 4. Programs for People with Limited Income and Resources

Lesson 1 - Program Basics What is Medicare? Enrolling in Medicare The Parts of Medicare

Lesson 1 Program Basics explains

- What is Medicare?
- Enrolling in Medicare
- The Parts of Medicare

What is Medicare?

- Health insurance for three groups of people
 - 65 and older
 - Under 65 with certain disabilities
 - Any age with End-Stage Renal Disease (ESRD)
- Administration
 - Centers for Medicare & Medicaid Services

04/28/2011

Understanding Medicare

- President Lyndon Johnson signed the Medicare and Medicaid programs into law July 30, 1965. Medicaid became effective January 1, 1966, and Medicare became effective July 1, 1966. Medicare is the nation's largest health insurance program, currently covering about 44 million Americans.
- Medicare is health insurance for three groups of people.
 - Those who are age 65 and older
 - People under age 65 with certain disabilities who are entitled to Social Security disability or Railroad Retirement benefits for 24 months. The 24-month Medicare waiting period does not apply to people disabled by Amyotrophic Lateral Sclerosis (ALS, known as Lou Gehrig's Disease). People with ALS get Medicare the first month they are entitled to disability benefits. This provision became effective on July 1, 2001.
 - People of any age who have End-Stage Renal Disease (ESRD; permanent kidney failure requiring dialysis or a transplant)

Enrollment

- Automatic for those receiving
 - Social Security benefits
 - Railroad Retirement Board benefits
- Initial Enrollment Period Package
 - -Mailed 3 months before
 - 25th month of disability benefits
 - Age 65



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Understanding Medicare

• If you are already receiving Social Security benefits (for example, getting early retirement) you will be automatically enrolled in Medicare Part A and Part B without an additional application. You will receive you Initial Enrollment Period Package, which includes your Medicare card and other information, about 3 months before age 65 (coverage begins the first of the month you turn 65), or 3 months before your 25th month of disability benefits (coverage begins your 25th month of disability benefits).

NOTE: If you live in Puerto Rico or a foreign country and you get benefits from Social Security or the RRB, you will automatically get Part A. If you want Part B, you will need to sign up for it. Residents of Puerto Rico should contact your local Social Security office for more information. Residents of foreign countries can contact any U.S. consular office. You will not receive the IEP package pictured on the slide. You will get a different package.



Welcome to Medicare, CMS Product No. 11095 is pictured on this slide. It is part of the Initial Enrollment Period Package.

Enrolling in Medicare

- Some people need to sign up
 - Those not automatically enrolled
- Enroll through Social Security
 - Railroad Retirement Board for railroad retirees
- Apply 3 months before age 65
 - Don't have to be retired

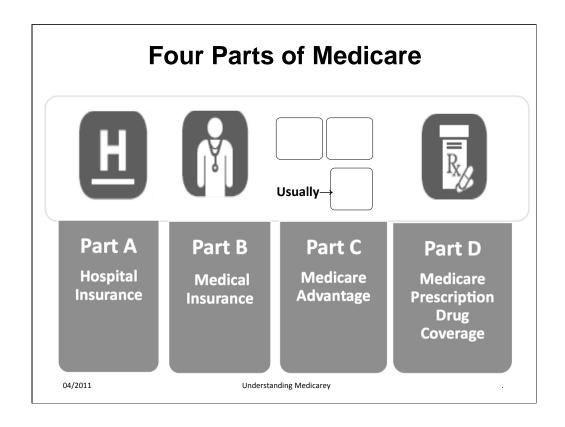
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Understanding Medicare

- If you aren't getting Social Security or RRB benefits (for instance, because you are still working), you will need to sign up for Part A (even if you are eligible to get it premium-free). You should contact Social Security 3 months before you turn age 65. If you worked for a railroad, contact the RRB to sign up.
- While Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), the Social Security Administration (SSA) is responsible for enrolling most people in Medicare. The Railroad Retirement Board (RRB) is responsible for enrolling railroad retirees in Medicare.
- Social Security advises people to apply for Medicare benefits 3 months before age 65. You do not have to be retired to get Medicare. The full retirement age for Social Security retirement benefits is now 66 (for persons born between 1943 and 1954) and will gradually increase 67 for persons born in 1960 or later, but you can still receive full Medicare benefits at age 65.

Medicare Card Keep it and accept Medicare Parts A and B Return it to refuse Part B Follow instructions on back of card Front Back HEALTH INSURANCE JANE DOE 000-00-0000-A HOSPITAL 07-01-1986 MEDICAL Jane Doe 04/28/2011 **Understanding Medicare** 8

- When you have Original Medicare, you use your red, white, and blue Medicare card when you get health care.
- This is a sample Medicare card. The Medicare card shows the Medicare coverage (Part A hospital coverage and/or Part B medical coverage) and the date the coverage starts. Note: Your card may look slightly different from this one; it's still valid.
- The Medicare card also shows your Medicare claim number. For most people, the claim number has 9 numerals and 1 letter. There also may be a number or another letter after the first letter. The 9 numerals show which Social Security record your Medicare is based on. The letter or letters and numbers tell how you are related to the person with that record. For example, if you get Medicare on your own Social Security record, you might have the letter "A," "T," or "M" depending on whether you get both Medicare and Social Security benefits or Medicare only. If you get Medicare on your spouse's record, the letter might be a B or a D. For railroad retirees, there are numbers and letters in front of the Social Security number. These letters and numbers have nothing to do with having Medicare Part A or Part B.
- If you choose another Medicare health plan, your plan may give you a card to use when you get health care services and supplies. You should contact Social Security (or the Railroad Retirement Board if you receive railroad retirement benefits), if any information on the card is incorrect.
- If you don't want Part B, follow the directions and return the card. We will talk more about why you might not want Part B later.



- Medicare covers many types of services, and people have options for how they can get their Medicare coverage. Medicare has four parts
- Part A (Hospital Insurance)
- Part B (Medical Insurance)
- Part C (Medicare Advantage) Includes Part A and Part B coverage and usually also includes Part D.
- Part D (Medicare Prescription Drug Coverage)

Medicare Part A Hospital Insurance ■Costs ■Coverage —Inpatient hospital stays —Skilled nursing facility care —Home health care —Hospice care —Blood Understanding Medicare 10

Medicare Part A Hospital Insurance

- Costs
- Coverage
 - Inpatient hospital stays
 - Skilled nursing facility care
 - Home health care
 - Hospice care
 - Blood

Medicare Part A (Hospital Insurance)

- Most people receive Part A premium free
 - If you paid FICA taxes at least 10 years
- If you paid FICA less than 10 years
 - Can pay a premium to get Part A
 - May have penalty if not bought when first eligible

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- Medicare Part A is premium free if you or your spouse paid Medicare, or Federal Insurance Contributions Act (FICA), taxes while working (10 year minimum in most cases). FICA funds the Social Security and Medicare programs.
- If either you or your spouse doesn't qualify for premium-free Medicare Part A, you may still be able to get Medicare Part A by paying a monthly premium. The amount of the premium depends on how long you or your spouse worked in Medicare-covered employment.
 - SSA determines if you have to pay a monthly premium for Part A.
 - In 2011, the Part A monthly premium is \$248 (for a person who has worked 30-39 quarters) or \$450 (for a person who has worked less than 30 quarters) of Medicare-covered employment.
 - If you don't buy Medicare Part A when you are first eligible, you may have to pay a monthly premium penalty. The premium is subject to a 10% increase payable for twice the number of full twelve month periods you could have been but were not enrolled. The 10% premium surcharge will apply only after 12 months have elapsed from the last day of the IEP to the last date of the enrollment period you used to enroll. In other words, if it is less than 12 months, the penalty will not apply. This penalty won't apply to you if you are eligible for a special enrollment period (anytime that you or your spouse (or family member if you're disabled) are working, and you're covered by a group health plan through the employer or union based on that work or during the 8-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first).



For information on Medicare Part A entitlement, enrollment, or premiums, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

| Medicare Part A Covered Services | | | | | |
|----------------------------------|----------------------------------------------------------------------------------------------------------------|--|--|--|--|
| Inpatient | Semi-private room, meals, general nursing, and other | | | | |
| Hospital Stays | hospital services and supplies. Includes care in critical | | | | |
| | access hospitals and inpatient rehabilitation facilities. Inpatient mental health care in psychiatric hospital | | | | |
| | (lifetime 190-day limit). Generally covers all drugs provided | | | | |
| | during an inpatient stay received as part of your treatment | | | | |
| Skilled Nursing | Semi-private room, meals, skilled nursing and rehabilitation | | | | |
| Facility Care | services, and other services and supplies. | | | | |
| Home Health | Can include part-time or intermittent skilled care, and | | | | |
| Care Services | physical therapy, speech-language pathology, a continuing | | | | |
| | need for occupational therapy, some home health aide | | | | |
| | services, medical social services, and medical supplies. | | | | |
| Hospice Care | For terminally ill and includes drugs, medical care, and | | | | |
| | support services from a Medicare-approved hospice. | | | | |
| Blood | In most cases, if you need blood as an inpatient, you won't | | | | |
| | have to pay for it or replace it. | | | | |
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- Medicare Part A, hospital insurance covers medically necessary services.
 - Hospital inpatient care Semi-private room, meals, general nursing, and other hospital services and supplies. Includes care in critical access hospitals and inpatient rehabilitation facilities. Inpatient mental health care in a psychiatric hospital (lifetime 190-day limit). Coverage does not include private duty nursing, television or telephone in your room if there are separate charges for these items, and private rooms unless medically necessary. Generally covers all drugs provided during an inpatient stay received as part of your treatment.
 - Skilled nursing facility (SNF) care (not custodial or long-term care) Semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies.
 - Home health care services Covers medically-necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology services, a continuing need for occupational therapy, home health aide services, medical social services, and medical supplies. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. You must be homebound, which means that leaving home is a major effort. You pay nothing for covered home health services.
 - Hospice Care For people with a terminal illness. Your doctor must certify that you are expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; and other covered services as well as services Medicare usually doesn't cover, such as grief counseling.
 - Blood In most cases, if you need blood as an inpatient, you won't have to pay for it or replace it.

Benefit Periods

- Measures use of inpatient hospital and skilled nursing facility (SNF) services
- Begins the day you first receive inpatient care
 - In hospital or skilled nursing facility
- Ends when not in hospital/SNF 60 days in a row
- Pay Part A deductible for each benefit period
 - \$1,132 in 2011
- No limit to number of benefit periods

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Understanding Medicare

- A benefit period refers to the way Medicare measures your use of hospital and skilled nursing facility (SNF) services.
 - A benefit period begins on the day you first receive inpatient care in a hospital or skilled nursing facility.
 - The benefit period ends when you are not in a hospital, or receiving skilled nursing care in a skilled nursing facility for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins.
 - You must pay the inpatient hospital deductible (\$1,132 in 2011) for each benefit period.
 - There is no limit to the number of benefit periods you can have.

| Paying for Inpatient Hospital Stays | | | | |
|-------------------------------------|---------------------------------------------|----|--|--|
| For each benefit period in 2011 | You Pay | | | |
| Days 1-60 | \$1,132 deductible | | | |
| Days 61-90 | \$283 per day | | | |
| Days 91-150 | \$566 per day (60 lifetime reserve days) | | | |
| All days after 150 | All Costs | | | |
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- For each benefit period in 2011 you pay
 - A total of \$1,132 for a hospital stay of 1-60 days
 - \$283 per day for days 61-90 of a hospital stay
 - \$566 per day for days 91-150 of a hospital stay (Lifetime Reserve Days). Original Medicare will pay for a total of 60 extra days—called "lifetime reserve days"—when you are in a hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you don't get any more extra days during your lifetime.
 - All costs for each day beyond 150 days

Skilled Nursing Facility Care

- Must meet all conditions
 - Require daily skilled services
 - · Not just long-term or custodial care
 - Hospital inpatient 3 consecutive days or longer
 - Admitted to SNF within specific timeframe
 - · Generally 30 days after leaving hospital
 - SNF care must be for a hospital-treated condition
 - Or condition that arose while receiving care in the SNF for hospital-treated condition
 - MUST be a Medicare-participating SNF

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- Medicare Part A will pay for skilled nursing facility (SNF) care for people with Medicare who meet all of the following conditions.
 - Your condition requires daily skilled nursing or skilled rehabilitation services which can only be provided in a skilled nursing facility.
 - This does not include custodial or long-term care. Medicare doesn't cover custodial care if it is the only kind of care you need. Custodial care is care that helps you with usual daily activities, like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of a colostomy or bladder catheters. Custodial care is often given in a nursing facility. Generally, skilled care is available only for a short time after a hospitalization. Custodial care may be needed for a much longer period of time.
 - You were an inpatient in a hospital, 3 consecutive days or longer, before you were admitted
 to a participating SNF. It's important to note that an overnight stay doesn't guarantee that
 you are an inpatient. An inpatient hospital stay begins the day you are formally admitted
 with a doctor's order, and doesn't include the day you are discharged.
 - You were admitted to the SNF within 30 days after leaving the hospital.
 - Your care in the SNF is for a condition that was treated in the hospital or arose while receiving care in the SNF for hospital-treated condition.
 - The facility MUST be a Medicare participating SNF.

Skilled Nursing Facility Coverage

- Semi-private room
- Meals
- Skilled nursing care
- Physical, occupational and speech-language therapy
- Medical social services
- Medications, medical supplies/equipment
- Ambulance transportation (limited)
- Dietary counseling

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Understanding Medicare

- If you qualify, Medicare will cover the following SNF services:
 - Semi-private room (a room you share with one other person)
 - Meals
 - Skilled nursing care
 - Physical, occupational and speech-language therapy (if needed to meet your health goal)
 - Medical social services
 - Medications, and medical supplies/equipment used in the facility
 - Ambulance transportation, when other transportation endangers health, to the nearest supplier of needed services that are not available at the SNF
 - Dietary counseling

| Paying for Skilled Nursing Facility Care For each benefit period | | | | |
|-------------------------------------------------------------------|---------------------------|--|--|--|
| in 2011 | You Pay | | | |
| Days 1-20 | \$0 | | | |
| Days 21-100 | \$141.50 per day | | | |
| All days after 100 | All Costs | | | |
| | | | | |
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- Skilled nursing facility (SNF) care is covered in full for the first 20 days when you meet the requirements for a Medicare-covered stay. In 2011, under Original Medicare, days 21 100 of SNF care is covered except for coinsurance of up to \$141.50 per day, each benefit period. After 100 days, Medicare Part A no longer covers SNF care.
- You can qualify for skilled nursing care again every time you have a new benefit period.

Five Conditions for Home Health Care

- Must be homebound
- Must need skilled care on intermittent basis
- Must be under care of a physician
 - Receiving services under a plan of care
- Have face-to-face encounter with doctor New In 2011
 - Prior to start of care
- Home health agency must be Medicareapproved

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- To be eligible, you must meet all of these conditions:
 - You must be homebound, which means that you are normally unable to leave home or that leaving home is a major effort. When you leave home, it must be infrequent, for a short time, or to get medical care (may include adult day care) or attend a religious service.
 - You must need skilled care on an intermittent basis, or physical therapy, or speechlanguage pathology, or have a continuing need for occupational therapy.
 - Your doctor must decide that you need skilled care in your home and must make a plan for your care at home.
 - Prior to certifying a patient's eligibility for the Medicare home health benefit, the
 physician must document that the physician or a non-physician practitioner has had a
 face-to-face encounter with the patient. Section 6407 is largely a Medicare provision
 but it applies to Medicaid in the same manner and to the same extent in the case of
 physicians authorizing home health services.
 - •The encounter must be done up to 90 days prior, or within 30 days after the start of care.
 - •Telehealth may be used if provisions are met per 1834(m).
 - The home health agency caring for you must be approved by Medicare.

NOTE: Part B also may pay for home health care under certain conditions. For instance, Part B pays for home health care if an inpatient hospital stay does not precede it, or when the number of Part A-covered home health care visits exceed 100.

Paying for Home Health Care

- Fully covered by Medicare
- Plan of care reviewed every 60 days
 - Called episode of care
- In Original Medicare you pay
 - Nothing for covered home health care services
 - 20% of Medicare-approved amount for durable medical equipment (covered by Part B)

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- In Original Medicare, for Part A covered home health care, you pay the following.
 - Nothing for covered home health care services provided by a Medicareapproved home health agency.
 - If you have Part B you pay 20% of the Medicare-approved amount for an assigned durable medical equipment claim. If the claim is non-assigned, the person with Medicare is responsible for whatever the durable medical equipment supplier charges over and above the Medicare-approved amount. (We will discuss assignment later.)

NOTE: Part A covers post-institutional home health services furnished during a home health spell of illness for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health spell of illness. The 100-visit limit does not apply to you if you are only enrolled in Part A. If you are enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are financed under Part B. There is no 100-visit limit under Part B.





To find a home health agency in your area, call 1-800-MEDICARE or visit www.medicare.gov and use the Home Health Compare tool.

Hospice Care

- Special care for the terminally ill and family
 - Expected to live 6 months or less
- Focus on comfort and pain relief, not cure
- Doctor must certify each "benefit period"
 - Two 90-day periods
 - Then unlimited 60-day periods
 - Face-to-face encounter New in 2011
- Hospice provider must be Medicare-approved

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- Part A also covers hospice care, which is a special way of caring for people who are terminally ill and their families. Hospice care is meant to help you make the most of the last months of life by giving you comfort and relief from pain. It involves a team that addresses your medical, physical, social, emotional, and spiritual needs. The goal of hospice is to care for you and your family, not to cure your illness.
- You can get hospice care as long as your doctor certifies that you are terminally ill and probably have less than 6 months to live if the illness runs its normal course. Care is given in "periods of care"—two 90-day periods followed by unlimited 60-day periods. Per Section 3132 of the Affordable Care Act, Medicare has added a new requirement for hospice face-to-face visits.
 - Requires doctor to meet with patient within 30 days of hospice recertification.
 - Starting before the third benefit period.
- You must sign a statement choosing hospice care instead of routine Medicare covered benefits to treat your terminal illness. However, medical services not related to the hospice condition would still be covered by Medicare.
- At the start of each benefit period, your doctor must certify that you are terminally ill for you to continue getting hospice care. Medicare must approve the hospice care provider.

Covered Hospice Services

- Physician and nursing services
- Medical equipment and supplies
- Drugs for symptom control and pain relief
- Short-term hospital inpatient care
- Respite care in a Medicare-certified facility
 - Up to 5 days each time, no limit to times
- Hospice aide and homemaker services
- Social worker services
- Grief, dietary and other counseling
- Physical, occupational, or speech therapy

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Understanding Medicare

- The hospice benefit covers many services that are out of the ordinary. In addition to the regular Medicare-covered services such as doctor and nursing care, physical and occupational therapy, and speech therapy, the hospice benefit also covers the following:
 - Medical equipment (such as wheelchairs or walkers)
 - Medical supplies (such as bandages and catheters)
 - Drugs for symptom control and pain relief
 - Short-term care in the hospital, hospice inpatient facility, or skilled nursing facility when needed for pain and symptom management
 - Inpatient respite care, which is care given to a hospice patient by another caregiver, so the usual caregiver can rest. You will be cared for in a Medicare-approved facility, such as a hospice inpatient facility, hospital, or nursing home. You can stay up to 5 days each time you get respite care, and there is no limit to the number of times you can get respite care. Hospice care is usually given in your home (or a facility you live in). However, Medicare also covers short-term hospital care when needed.
 - Hospice aide and homemaker services
 - Social worker services
 - Counseling to help you and your family with grief and loss
 - Dietary and other counseling

Paying for Hospice Care

- In Original Medicare you pay
 - Nothing for hospice care
 - Up to \$5 per Rx to manage pain and symptoms
 - · While at home
 - 5% for inpatient respite care
- Room and board may be covered
 - Short term respite care or for pain/symptom management
 - If you have Medicaid and live in nursing facility

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- For hospice care in Original Medicare, you pay a copayment of no more than \$5 for each prescription drug and other similar products for pain relief and symptom control, and 5% of the Medicare-approved payment amount for inpatient respite care. For example, if Medicare has approved a charge of \$150 per day for inpatient respite care, you will pay \$7.50 per day. The amount you pay for respite care can change each year.
- Room and board are only payable by Medicare in certain cases. Room and board are covered during short-term inpatient stays for pain and symptom management, and for respite care. Room and board are not covered if you receive general hospice services while a resident of a nursing home or a hospice's residential facility. However, if you have Medicaid as well as Medicare, and reside in an nursing facility, room and board are covered by Medicaid.



To find a hospice program, call 1-800-MEDICARE (1-800-633-4227) or your state hospice organization in the blue pages of your telephone book. TTY users should call 1-877-486-2048.

Blood (Inpatient)

- If hospital gets blood free from blood bank
 - You won't have to pay for it or replace it
- If hospital has to buy blood for you
 - You pay for first 3 units per a calendar year
 - You or someone else donates to replace blood

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- In most cases, the hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it.
- If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year, or have the blood donated by you or someone else.

Medicare Part B Medical Insurance

- What is covered
- Enrolling
- Keeping Part B
- Medicare and other coverage
- Premium
- Coverage
- Part B costs
- Assignment

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Medicare Part B Medical Insurance explains the following:

- What is covered
- Enrolling
- Keeping Part B
- Medicare and other coverage
- Premium
- Coverage
- Part B costs
- Assignment

| Medicare Part B Coverage | | | | | |
|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| Doctors' Services | Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. Except for certain preventive services, you pay 20% of the Medicare-approved amount (if the doctor accepts assignment), and the Part B deductible applies. | | | | |
| Outpatient Medical and Surgical Services and Supplies | For approved procedures (like X-rays, a cast, or stitches). You pay the doctor 20% of the Medicare-approved amount for the doctor's services if the doctor accepts assignment. You also pay the hospital a copayment for each service. The Part B deductible applies. | | | | |
| 04/28/2011 | Understanding Medicare 25 | | | | |

Medicare Part B covers a number of medically-necessary services and supplies. Certain requirements must be met.

- Doctors' Services Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. Except for certain preventive services, you pay 20% of the Medicare approved amount, and the Part B deductible applies.
- Outpatient Medical and Surgical Services and Supplies For approved procedures (like X-rays, a cast, or stitches). You pay the doctor 20% of the Medicare-approved amount for the doctor's services. You also pay the hospital a copayment for each service you get in a hospital outpatient setting. For each service, the copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies, and you pay all charges for items or services that Medicare doesn't cover.
- See slides 44 and 45 for information on assignment and the limiting charge.

| Medicare Part B Coverage | | | | | |
|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| Home Health Care Services | Medically necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology services, occupational therapy, part-time or intermittent home health aide services, medical social services, and medical supplies. Durable medical equipment and an osteoporosis drug are also covered under Part B. You pay nothing for covered services. | | | | |
| 04/28/2011 | Understanding Medicare 26 | | | | |

Medicare Part B covers a number of medically-necessary services and supplies. Certain requirements must be met.

- Home Health Care Services - Covers medically-necessary part-time or intermittent skilled nursing care, physical therapy, speech-language pathology services, a continuing need for occupational therapy, home health aide services, medical social services, and medical supplies. Durable medical equipment and an osteoporosis drug are also covered under Part B. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. You must be homebound, which means that leaving home is a major effort. You pay nothing for covered home health services.

NOTE: Part A covers post-institutional home health services furnished during a home health spell of illness for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health spell of illness. The 100-visit limit does **not** apply if you are only enrolled in Part A. If you are enrolled **only** in Part B and qualify for the Medicare home health benefit, then all of your home health services are financed under Part B. There is no 100-visit limit under Part B.

| Medicare Part B Coverage | | | | | |
|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| Durable Medical Equipment | Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds for use in the home. Some items must be rented. | | | | |
| | You pay 20% of the Medicare-approved amount, and the Part B deductible applies. | | | | |
| Other (including but not limited to) | Medically necessary medical services and supplies, such as clinical laboratory services, diabetes supplies, kidney dialysis services and supplies, mental health care, limited outpatient prescription drugs, diagnostic X-rays, MRIs, CT scans, and EKGs, transplants and other services are covered. Costs vary. | | | | |
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Durable Medical Equipment - Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In all areas of the country, you must get your covered equipment or supplies and replacement or repair services from a Medicare approved supplier for Medicare to pay.



See Section 4312(b) of the Balanced Budget Act.

- New—Medicare is phasing in a new program called "competitive bidding" to help save you and Medicare money; ensure that you continue to get quality equipment, supplies, and services; and help limit fraud and abuse. In some areas of the country if you need certain items, you must use specific suppliers, or Medicare won't pay for the item and you likely will pay full price. It's important to see if you're affected by this new program to ensure Medicare payment and avoid any disruption of service. This program is effective in parts of the following states: CA, FL, IN, KS, KY, MO, NC, OH, PA, SC, TX
- Other services covered include, but aren't limited to medically necessary clinical laboratory services, diabetes supplies, Kidney dialysis services and supplies, mental health care, limited prescription drugs, diagnostic X-rays, MRIs, CT scans, and EKGs, transplants and other services are covered. Costs vary.





More information on Medicare coverage is available in the *Medicare & You* handbook, CMS Product No. 10050 or *Your Medicare Benefits*, CMS Product No. 10116 available online at www.medicare.gov.

Part B Covered Preventive Services

- "Welcome to Medicare" examGlaucoma tests
- New in Yearly "Wellness" exam
 - Abdominal aortic aneurysm screening*
 - Bone mass measurement
 - Cardiovascular disease screenings
 - Colorectal cancer screenings
 - Diabetes screenings
 - Flu shots

- Hepatitis B shots
- HIV Screening
- Mammograms (screening)
- Pap test/pelvic exam/clinical breast exam
- Prostate cancer screening
- Pneumococcal pneumonia shots
- Smoking cessation

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- Medicare Part B also covers preventive services like exams, lab tests, screening and shots to help prevent, find, or manage a medical problem. Preventive services may find health problems early when treatment works best. Talk to your doctor about which preventive services you need and to find out if you meet the criteria for coverage. The Medicare & You handbook includes guidelines for who is covered and how often Medicare will pay for these services.
- Part B covered preventive services
 - "Welcome to Medicare" physical exam (one-time review of your health, education and counseling about the preventive services you need. To be covered, you must have the physical exam within the first 12 months you have Medicare Part B.)
 - Physical Exam (yearly wellness exam beginning January 2011) as result of ACA
 - Abdominal aortic aneurysm screening *
 - Bone mass measurement
 - Cardiovascular disease screenings
 - Colorectal cancer screenings
 - Diabetes screenings
 - Flu Shots

- Glaucoma tests
- Hepatitis B shots
- HIV screening
- Mammograms (screening)
- Pap test and pelvic exam (includes clinical breast examination)
- Prostate cancer screening
- Pneumococcal pneumonia shots
- Smoking cessation

*When referred during a "Welcome to Medicare" physical exam

NOTE: These services are discussed in depth in Module 7.

^{*}When referred during Welcome to Medicare physical exam

NOT Covered by Part A and Part B

- Long-term care
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting hearing aids
- Other check on www.medicare.gov

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- Medicare Part A and Part B don't cover everything. If you need certain services that Medicare doesn't cover, you will have to pay out-of-pocket unless you have other insurance to cover the costs. Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance, and copayments.
- Items and services that Medicare doesn't cover include, but aren't limited to, long-term care, routine dental care, dentures, cosmetic surgery, acupuncture, hearing aids, and exams for fitting hearing aids.

Medicare Dictionary:



Long Term Care - Long-term care includes medical and non-medical care for people who have a chronic illness or disability. Non-medical care includes non-skilled personal care assistance, such as help with everyday activities like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living, or in a nursing home. It's important to start planning for long-term care now to maintain your independence and to make sure you get the care you may need in the future.



To find out if Medicare covers a service you need, visit www.medicare.gov and select "Find Out What Medicare Covers," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



Part B Automatic Enrollment

- At age 65 if you get retirement benefits
- Under age 65 if disabled
 - After 24 months of disability benefits from SSA
 - Month disability begins if you have ALS
 - Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)
- Others must enroll themselves

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- In most cases, if you're already getting benefits from Social Security or the Railroad Retirement Board (RRB), you will automatically get Part A and Part B starting the first day of the month you turn 65. If your birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.
- If you're under 65 and disabled, you automatically get Part A and Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months.
- You will get your red, white, and blue Medicare card in the mail 3 months before your 65th birthday or your 25th month of disability. If you don't want Part B, follow the instructions that come with the card, and send the card back. If you keep the card, you keep Part B and will pay Part B premiums.
- If you live in Puerto Rico or a foreign country and you get benefits from Social Security or the RRB, you will automatically get Part A. If you want Part B, you will need to sign up for it. Residents of Puerto Rico should contact your local Social Security office for more information. Residents of foreign countries can contact any U.S. consular office.
- If you have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), you automatically get Part A and Part B the month your disability benefits begin.
- If you are not getting retirement benefits from Social Security or the Railroad Retirement Board you must enroll yourself to get Medicare. We'll talk about the periods when you can enroll later.

| If Not Automatically Enrolled Your 7-Month Initial Enrollment Period | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------|----------------------------------------|----------------------------------------|
| No Delay | | | Delayed Start | | | | |
| If you enroll in Part B | 3 months before the month you turn 65 | 2 months before the month you turn 65 | 1 month before the month you turn 65 | The month you turn 65 | 1 month after you turn 65 | 2 months after you turn 65 | 3 months after you turn 65 |
| Sign up early to avoid a delay in getting coverage for Part B services. To get Part B coverage the month you turn 65, you must sign up during the first three months before the month you turn 65. | | | If you wait until the last four months of your Initial Enrollment Period to sign up for Part B, your start date for coverage will be delayed. | | | | |
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- If you are not automatically enrolled, you can choose to sign up for Part B during your initial enrollment period (IEP).
- You can sign up for Part B any time during a 7-month IEP that begins 3 months before the month you become eligible for Medicare. You can choose whether or not to enroll in Part B. If you enroll you pay a monthly premium for Medicare Part B.
- Sign up during the first 3 months of your IEP to get your Part B coverage effective the month you turn 65. However, if your birthday is the first day of the month, your coverage will start the first day of the prior month.
- If you wait to sign up until the last four months of your IEP, your Part B start date will be delayed.

NOTE: If your date of birth is the first of the month, your effective date moves to the first of the month before your month of birth if you apply within the first 2 months of your IEP.

General Enrollment Period (GEP)

- January 1 through March 31 each year
- Coverage effective July 1
- Premium penalty
 - 10% for each 12-months eligible but not enrolled
 - Must pay as long as you have Part B
 - Limited exceptions

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- If you don't take Part B when first eligible, you may have to wait to sign up during the annual General Enrollment Period (GEP) which runs from January 1 through March 31 of each year. Your coverage will be effective July 1 of that year.
- Premium penalty If you don't take Part B when you are first eligible, you will have to pay a premium penalty of 10% for each full 12-month period they could have had Part B but didn't sign up for it, except in special situations. In most cases, they will have to pay this penalty for as long as you have Part B.

Paying for Part B Services

- In Original Medicare you pay
 - Yearly deductible of \$162 in 2011
 - 20% coinsurance for most services
- Some programs may help pay these costs

- If you have Original Medicare, you pay the Part B deductible, which is the amount a person must pay for health care each calendar year before Medicare begins to pay. This amount can change every year in January. The 2011 Part B deductible is \$162 per year. This means that you must pay the first \$162 of your Medicareapproved medical bills in 2011 before Medicare Part B starts to pay for your care.
- You also pay some copayments or coinsurance for Part B services. The amount depends upon the service, but is 20% in most cases.
- If you can't afford to pay these costs, there are programs that may help. These programs are discussed later in this presentation. See Lesson 4.

| If your Yearly Income in 2009 was You Pay | | | | |
|--------------------------------------------------|---------------------|------------|--|--|
| File Individual Tax Return | | | | |
| \$85,000 or below | | \$96.40* | | |
| | \$170,000 or below | \$110.50 | | |
| | | \$115.40 | | |
| \$85,001–\$107,000 | \$170,001-\$214,000 | \$161.50 | | |
| \$107,001–\$160,000 | \$214,001-\$320,000 | \$230.70 | | |
| \$160,001–\$214,000 | \$320,001-\$428,000 | \$299.90 | | |
| above \$214,000 | above \$428,000 | \$369.10 | | |
| *Most people pay \$96.40 if the Social Security. | | ucted from | | |

- The 2009 Part B premium was \$96.40. The Part B premium in 2010 was \$110.50. The Part B premium in 2011 is \$115.40. If your Part B premium was withheld from your Social Security payment prior to 2011, and have an income of \$85,000 or less (or \$170,000 or less for joint filers) you will not have an increase in your Part B premium in 2011, and you will continue to pay the 2009 premium of \$96.40, or the 2010 premium of \$110.50, whichever applies.
- Some people with higher annual incomes pay a higher Part B premium. These amounts can change each year. See below for 2011 Part B premiums based on the modified adjusted gross income for an individual.
 - \$85,001 \$107,000, the Part B premium is \$161.50 per month
 - \$107,001 \$160,000, the Part B premium is \$230.70 per month
 - \$160,001 \$214,000 the Part B premium is \$299.90 per month
 - Greater than \$214,000, the Part B premium is \$369.10 per month
- The income ranges for joint returns are double that of individual returns. Social Security uses the income reported on your tax return from two years ago to determine the Part B premium. For example, the income reported on a 2009 tax return filed in 2010 is used to determine the monthly Part B premium in 2011. Remember that this premium may be higher if you did not choose Part B when you first became eligible. The cost of Medicare Part B may go up 10% for each 12-month period that you could have had Part B but did not take it. An exception would be if you or your spouse or family member if you're disabled, is still employed and you are covered by a group health plan through that employment. In that case, you are eligible to enroll in Part B during a special enrollment period. You will not pay a penalty. See slide 39.



Contact Social Security at 1-800-772-1213 if you filed an amended return or your income has gone down.

Paying the Part B Premium

- Deducted monthly from
 - Social Security
 - Railroad retirement
 - Federal retirement payments
- If not deducted
 - Billed every 3 months
 - Medicare Easy Pay to deduct from bank account
- Contact SSA, RRB or OPM about premiums

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- The Part B premium is deducted from monthly Social Security, Railroad Retirement or Federal retirement payments.
- People who don't get a retirement payment or whose payment is not enough to cover the premium get a bill from Medicare for the Part B premiums.
 - The bill can be paid by credit card, check, or money order.
- For information about Medicare Part B premiums, call SSA, RRB, or the Office of Personnel Management (OPM) for retired Federal employees.
- If you can't afford to pay the Part B premium, there are programs that may help you.
 See Lesson 4.

Part B Late Enrollment Penalty

- Penalty for not signing up when first eligible
 - 10% more for each full 12-month period
 - May have penalty as long as you have Part B
- Sign up during a Special Enrollment Period
 - Usually no penalty

- If you don't sign up for Part B when you are first eligible, you may have to pay a late enrollment penalty for as long as you have Medicare.
- Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but didn't sign up for it.
- Usually, you don't pay a late enrollment penalty if you sign up for Part B during a special enrollment period (SEP). See slide 39.

Part B Late Enrollment Penalty Example

Mary delayed signing up for Part B two full years after she was eligible. She will pay a 10% penalty for each full 12-month period she delayed. The penalty is added to the Part B monthly premium (\$115.40 in 2011). So for 2011, her premium will be as follows.

\$115.40 (2011 Part B standard premium)

+ \$23.08 (20% [of \$115.40] (2 X 10%)

\$138.48 (Round up) (For this example only)

\$138.50 (Mary's Part B monthly premium for 2011)

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This is an example of how the Part B late enrollment penalty is calculated:

- Mary delayed signing up for Part B two full years, so that is two 12-month periods. She must pay a 10% penalty for each 12-month period she delayed signing up for Part B after she was first eligible. She is not eligible for a special enrollment period.
- Since she is just joining, she has not previously had her premium deducted from Social Security or Railroad Retirement benefits, and her income is under \$85,000. So her standard premium for 2011 is \$115.40.
- The 20% penalty on the \$115.40 premium is \$23.08.
- The amount is rounded. In this case it is rounded up to \$23.10
- Mary's total premium for 2011 is \$138.50.
- She would not have to pay a late enrollment penalty if she were eligible for a special enrollment period.

Part B and Employer or Union Coverage

- May affect your Part B enrollment rights
 - -You may want to delay enrolling in Part B if
 - · You have employer or union coverage and
 - You or your spouse, or family member if you are disabled, is still working
- See how your insurance works with Medicare
 - Contact your employer/union benefits administrator

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- Having coverage through an employer (including the Federal Employee Health Benefits Program) or union while you or your spouse, or family member if you are disabled, is still working can affect your Part B enrollment rights.
- You should contact your employer or union benefits administrator to find out how your insurance works with Medicare and if it would be to your advantage to delay Part B enrollment.

When Employer or Union Coverage Ends

- When your employment ends
 - -You may get a chance to elect COBRA
 - You may get a Special Enrollment Period
 - Sign up for Part B without a penalty
- Medigap open enrollment period
 - Starts when you are both 65 and sign up for Part B
 - Once started cannot be delayed or repeated

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- When your employment ends, and you are not enrolled in Part B, three things can happen:
 - You may get a chance to elect COBRA coverage, which continues your health coverage through the employer's plan (in most cases for only 18 months) and probably at a higher cost to you.
 - You may get a special enrollment period to sign up for Part B without a penalty. This period will run for 8 months and begins the month after your employment ends. This period will run whether or not you elect COBRA. If you elect COBRA, don't wait until your COBRA ends to enroll in Part B. If you enroll in Part B after the 8-month special enrollment period, you may have to pay a late enrollment penalty and you will have to wait until the next general enrollment period to enroll.
 - As we can see from this training module, Medicare doesn't pay all health care costs. One way to cover the costs or "gaps," is to purchase a Medigap policy. We will discuss these in more detail later, but it is important to know that when you sign up for Part B, you have a 6-month Medigap open enrollment period which gives you a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy. Once this period starts, it can't be delayed or repeated. Medigap policies are explained on slides 48-50.

Medicare and TRICARE Coverage

- Medicare Part A and TRICARE For Life
 - -If retired you must have Part B to keep TRICARE
- Active-duty member, spouse or dependent child
 - -You don't have to have Part B to keep TRICARE
- You get a Part B special enrollment period
 - -If you have Medicare because you are age 65 or
 - -Because you are disabled

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- If you have Medicare Part A and TRICARE (coverage for active-duty military or retirees and their families), you must have Part B to keep your TRICARE coverage.
- However, if you are an active-duty service member, or the spouse or dependent child of an active-duty service member, the following applies to you:
 - You don't have to enroll in Part B to keep your TRICARE coverage while the service member is on active duty.
 - When the active-duty service member retires, you must enroll in Part B to keep your TRICARE coverage.
 - You can get Part B during a special enrollment period if you have Medicare because you are age 65 or older, or you are disabled.

NOTE: If you are in a Medicare Advantage Plan or choose to join a plan, tell the plan that you have TRICARE so your bills can be paid correctly.

Lesson 2 – Your Medicare Coverage Choices

- Original Medicare (Part A and Part B)
- Medicare Advantage Plans (Part C)
- Medicare Prescription Drug Coverage (Part D)

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In Lesson 2 we will discuss Medicare coverage choices

- Original Medicare (Part A and Part B)
- Medicare Advantage (Part C) and Other Medicare Plans
- Medicare Prescription Drug Coverage (Part D)

Original Medicare

- ■What is Original Medicare?
- Assignment
- ■Private Contracts
- ■Medigap Policies

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Original Medicare explains the following:

- What is Original Medicare?
- Assignment
- Private Contracts
- Medigap Policies

What is Original Medicare?

- Health care option run by the Federal government
- Provides your Part A and/or Part B coverage
- See any doctor or hospital that accepts Medicare
- You pay
 - Part B premium (Part A free for most people)
 - Deductibles, coinsurance or copayments
- Get Medicare Summary Notice (MSN)
- Can join a Part D plan to add drug coverage

- Original Medicare is one of the coverage choices in the Medicare program. You will be in Original Medicare unless you choose to join a Medicare Advantage Plan or other Medicare plan. Original Medicare is a fee-for-service program that is managed by the Federal Government.
- If you have Medicare Part A, you get all the Part A-covered services. If you have Medicare Part B, you get all the Part B-covered services. As we mentioned earlier, Part A (hospital insurance) is premium-free for most people. For Medicare Part B (medical insurance) you pay a monthly premium. The Part B premium in 2011 is \$115.40. In 2010 is was \$110.50. Beneficiaries who currently have Social Security withhold their Part B premium and have incomes of \$85,000 or less (or \$170,000 or less for joint filers) will not have an increase in their Part B premium in 2011, and will continue to pay the 2009 premium of \$96.40, or the 2010 premium of \$110.50, whichever applies.
- With Original Medicare, you can go to any doctor, supplier, hospital, or facility that accepts Medicare and is accepting new Medicare patients.
- In Original Medicare, you also pay deductibles and coinsurance or copayments. After you receive health care services, you'll get a letter in the mail, called a Medicare Summary Notice (MSN), that lists the services you received, what was charged, what Medicare paid, and how much you may be billed. If you disagree with the information on the MSN or with any bill you receive, you can file an appeal. There is information on the MSN about how to ask for an appeal.
- You can join a Medicare Prescription Drug Plan (Part D plan) to add drug coverage.

Assignment

- Doctor, provider, supplier accepts assignment
 - Signed an agreement with Medicare
 - Or is required by law
 - Accept the Medicare-approved amount
 - As full payment for covered services
 - Only charge Medicare deductible/coinsurance amount

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- Most accept assignment
 - They submit your claim to Medicare directly

- Assignment means that your doctor, provider, or supplier has signed an agreement with Medicare (or is required by law) to accept the Medicareapproved amount as full payment for covered services.
- Most doctors, providers, and suppliers accept assignment, but you should always check to make sure, because some who are enrolled in Medicare don't accept assignment.
- In some cases, doctors, providers, and suppliers must accept assignment, like when they have a participation agreement with Medicare and give you Medicarecovered services.

Suppliers and Assignment

- Suppliers that don't accept assignment
 - May charge you more
 - The limiting charge is 15% more
 - · May have to pay entire charge at time of service
- Providers sometimes must accept assignment
 - Medicare Part B-covered prescription drugs
 - Ambulance suppliers

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- If your doctor ,provider ,or supplier doesn t accept assignment:
 - You might have to pay the entire charge at the time of service, and then submit your claim to Medicare to get paid back using form CMS-1490S. Visit www.medicare.gov/medicareonlineforms for the form and instructions, or call 1-800-MEDICARE.
 - They may charge you more than the Medicare-approved amount, but there is a limit called "the limiting charge." They can only charge you up to 15% over the Medicareapproved amount. The limiting charge applies only to certain services and doesn't apply to some supplies and durable medical equipment.

Caution: If you get your Medicare Part B-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare program, they are supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. They can't charge you for submitting a claim. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Private Contracts

- Agreement between you and your doctor
 - Doctor doesn't furnish services through Medicare
 - Original Medicare and Medigap will not pay
 - Other Medicare plans will not pay
 - You will pay full amount for the services you get
 - No claim should be submitted
 - Cannot be asked to sign in an emergency

- A private contract is an agreement between you and a doctor who has decided not to furnish services through the Medicare program. The private contract only applies to services given by the doctor who asked you to sign it. This means that Medicare and Medigap (Medicare Supplement Insurance) will not pay for the services you get from the doctor with whom you have a private contract. You cannot be asked to sign a private contract in an emergency or for urgently needed care. You still have the right to see other Medicare doctors for services.
- If you sign a private contract with your doctor
 - No Medicare payment will be made for the services you get from this doctor.
 - Your Medigap policy, if you have one, will not pay anything for this service. (Call your insurance company before you get the service.)
 - You will have to pay whatever this doctor or provider charges you. (The Medicare limiting charge will not apply.)
 - Other Medicare plans will not pay for these services.
 - No claim should be submitted, and Medicare will not pay if one is submitted.
 - Many other insurance plans will not pay for the service either.
 - The doctor cannot bill Medicare for any services for anyone with Medicare for 2 years.

Medigap Policies

- Medigap (Medicare Supplement Insurance) policies
 - Private health insurance for individuals
 - Sold by private insurance companies
 - Supplement Original Medicare coverage
 - Follow Federal/state laws that protect you

- Medigap (Medicare Supplement Insurance) policies
 - Are private health insurance that cover only the policyholder, not the spouse
 - Are sold by private insurance companies
 - Supplement Original Medicare (help pay for "gaps" in Original Medicare coverage - like deductibles, coinsurance and copayments)
 - Pay for Medicare-covered services provided by any doctor, hospital, or provider that accepts Medicare (the exception is Medigap SELECT policies that require you use specific hospitals, and in some cases, specific doctors to get full benefits.)
 - May cover certain things Medicare doesn't depending on the Medigap plan
 - Must follow Federal and state laws that protect people with Medicare

Medigap

- Costs vary by plan, company, and location
- Medigap insurance companies can only sell a "standardized" Medigap policy
 - Identified in most states by letters
 - MA, MN, and WI standardize their plans differently
- Does not work with Medicare Advantage
- No networks except with a Medicare SELECT policy
- You pay a monthly premium

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- In all states except Massachusetts, Minnesota, and Wisconsin, Medigap policies must be one of the standardized plans A, B, C, D, F, G, K, L, M or N so they can be easily compared. Each plan has a different set of benefits that are the same for any insurance company. It's important to compare Medigap policies, because costs can vary. (Note: Each company decides which Medigap policies it will sell and the price for each plan, with state review and approval.)
- A Medigap policy only works with Original Medicare (not with Medicare Advantage (MA) or other Medicare plans). It is illegal for anyone to sell you a Medigap policy if you
 - Are in a Medicare Advantage Plan (unless your enrollment is ending).
 - Have Medicaid (unless Medicaid pays for your Medigap policy or only pays your Medicare Part B premium).
 - Already have a Medigap policy (unless you cancel your old Medigap policy).
- You may want to drop your Medigap policy if you join a Medicare Advantage Plan or other Medicare plan. Even though you are entitled to keep it, it can't pay for benefits that you get under your MA or other Medicare plan and can't pay any cost-sharing under these plans.
- If you are in Original Medicare and you have a Medigap policy, you can go to any doctor, hospital, or other health care provider that accepts Medicare. However, if you have a type of Medigap policy called **Medicare SELECT**, you must use specific hospitals and, in some cases, specific doctors to get full insurance benefits.

See Module 3 for more information about Medigap policies.

| | | | | | Me | digap | Plans | | | |
|----------------------------------------------------------------|---|-----|----------|---------|----------|----------|----------|----------|----------|---|
| Medigap Benefits | Α | В | С | D | F* | G | K** | L** | М | N |
| Part A Coinsurance | ~ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Up to 365 Days | ~ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Part B Coinsurance | ~ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Blood | 1 | ✓ | 1 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hospice Care Coinsurance | 1 | ✓ | 1 | 1 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Skilled Nursing Coinsurance | | | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ |
| Part A Deductible | | ✓ | 1 | 1 | ✓ | ✓ | 50% | 75% | 50% | ✓ |
| Part B Deductible | | | ✓ | | ✓ | | | | | |
| Part B Excess Charges | | | | | ✓ | ✓ | | | | |
| Foreign Travel Emergency (Up to Plan Limits) | | | ✓ | 1 | √ | √ | | | ✓ | ✓ |
| *Plan F has a high-deductible ** Plans K and L have out-of- | | | its of | \$4,6 | 40 an | d \$2,3 | 320 resp | ectively | , | |
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- Basic benefits are covered by all Medigap plans. They include
 - Medicare Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up
 - Medicare Part B coinsurance or copayment
 - Blood (First 3 Pints)
 - Part A Hospice Care coinsurance or copayment

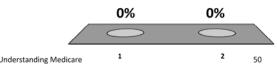
NOTE: Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to \$50 copayment for emergency room visits that don't result in an inpatient admission.

- Each Medigap Plan covers different benefits.
- The Skilled Nursing Facility care coinsurance is covered by Medigap Plans C, D, F, G, K (at 50%), L (at 75%), M, and N.
- The Medicare Part A deductible is covered by Medigap Plans B, C, D, F, G, K (at 50%), L (at 75%), M (at 50%) and N.
- The Medicare Part B deductible is covered by Medigap Plans C and F.
- The Medicare Part B excess charges are covered by Medigap Plans F and G.
- Foreign travel emergency costs up to the plan's limits are covered by Medigap Plans C, D, F, G, M and N.
- A full size copy of this chart is provided in the corresponding workbook. See Appendix A.

NOTE: *Plan F also offers a high-deductible plan. Plans K and L have out-of-pocket limits of \$4,640 and \$2,320 respectively.

Exercise

- A. The Centers for Medicare & Medicaid Services is responsible for enrolling most people in Medicare.
 - 1. True
 - 2. False

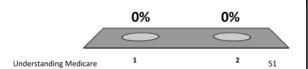


04/28/2011

Exercise

- B. The Part B premium most people will pay in 2011 is \$96.40.
 - 1. True
 - 2. False

04/28/2011



Medicare Advantage Plans

- What they are
- Who can join
- How the plans work
- When to join and switch plans
- Medicare Advantage Plan costs
- Other Medicare plans

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Medicare Advantage Plans

- What they are
- Who can join
- How the plans work
- When to join and switch plans
- Medicare Advantage Plan costs
- Other Medicare plans

See Module 11 for more information on Medicare Advantage Plans.

NOTE: In this lesson, when we use the term "Medicare Advantage Plans," we mean those with and without prescription drug coverage. Unless we state otherwise, we also intend the term to include other Medicare plans. (We will not include Original Medicare or stand-alone Medicare Prescription Drug Plans.)

Medicare Advantage (MA) Plans

- Health plan options approved by Medicare
- Also called Medicare Part C
- Run by private companies
- Medicare pays amount for each member's care
- Another way to get Medicare coverage
- Part of the Medicare program
- May have to use network doctors or hospitals

04/28/2011

Understanding Medicare

- Medicare Advantage Plans are health plan options that are approved by Medicare. Medicare Advantage Plans are offered in many areas of the country by private companies that sign a contract with Medicare.
- They are part of the Medicare program, and are sometimes called Medicare Part C.
- Medicare pays a set amount of money to these private health plans for their members' health care.
- You are still in the Medicare program.
- In a Medicare Advantage Plan, you may have to use doctors and hospitals that belong to the plan.

How Medicare Advantage Plans Work

- Still in Medicare with all rights and protections
- Still get regular Medicare-covered services
 - Some plans may provide additional benefits
- Plan may include prescription drug coverage
- May include extra benefits like vision or dental
- Benefits and cost-sharing may be different

- You still have Medicare rights and protections.
- You still get all your regular Medicare-covered services offered under Part A and Part B.
- You may get additional benefits offered through the plan, including Medicare prescription drug coverage. Other extra benefits could include coverage for vision, hearing, or dental care, and/or health and wellness programs.
- Benefits and cost-sharing may be different than in Original Medicare.

Medicare Advantage Eligibility Requirements

- You must live in plan's service area
- You must have Medicare Part A and Part B
- You must not have ESRD when you enroll
 - Some exceptions
- You must provide necessary information
- You must follow plan's rules
- You can only belong to one plan at a time

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Understanding Medicare

- Medicare Advantage Plans are available to most people with Medicare. To be eligible to join a Medicare Advantage Plan, you must
 - Live in the plan's geographic service area or continuation area
 - Have Medicare Part A and Part B
 - Not have End-Stage Renal Disease (ESRD). People with ESRD usually can't join a Medicare Advantage Plan or other Medicare plan. However, there are some exceptions.
- In addition, you must
 - Agree to provide the necessary information to the plan
 - Agree to follow the plan's rules
 - Belong to only one plan at a time
- To find out what Medicare Advantage Plans are available in your area, visit www.medicare.gov and choose the link Compare Health Plans and Medigap Policies in Your Area to use the Medicare Options Compare tool, or call 1-800-MEDICARE (1-800-633-4227).

Types of Medicare Advantage Plans

- Medicare Advantage Plans include
 - Health Maintenance Organization (HMO)
 - Preferred Provider Organization (PPO)
 - Private Fee-for-Service (PFFS)
 - Special Needs Plan (SNP)
 - HMO Point-of-Service Plan (HMOPOS)
 - Medicare Medical Savings Account (MSA)
- Not all types of plans are available in all areas

- There are five main types of Medicare Advantage Plans. They are
 - Medicare Health Maintenance Organizations (HMO) Plans—managed care plans that cover all Part A and B services and may provide extra services. You can generally only go to doctors, specialists, or hospitals that are part of the plan's network, except in an emergency.
 - Medicare Preferred Provider Organization (PPO) Plans—similar to an HMO plan, but members
 can see any doctor or provider that accepts Medicare, and they don't need a referral to see a
 specialist. Going to a provider that isn't part of the plan's network will usually cost more.
 - Medicare Private Fee-for-Service (PFFS) Plans—members can go to any provider that accepts
 the plan's terms, and may get extra benefits. The private company decides its share and
 member's share for services.
 - Medicare Special Needs (SNP) Plans—membership is limited to certain groups of people, such
 as those in certain institutions (like a nursing home), those eligible for both Medicare and
 Medicaid, or those with certain chronic or disabling conditions.
 - HMO Point-of-Service (HMOPOS) Plans—an HMO plan that may let you get some services out
 of network for a higher cost.
 - Medicare Medical Savings Account (MSA) Plans—two part plans similar to Health Savings Account plans available outside of Medicare. These MA plans have high deductibles that must be met before plan begins to pay covered costs. Deductibles vary by plan. The second part of this type plan is a Medical Savings Account into which Medicare deposits money that you may use to pay health care costs.
 - Not all types of plans are available in all areas

| Initial Enrollment Period | 7 month period begins 3 months before the month you turn 65 |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Annual Enrollment Period | ■ October 15 – December 7 ■ Coverage begins January 1 |
| Special Enrollment Period | Move from the plan service area And cannot stay in the plan Plan leaves Medicare program Other special situations |

- You can join a Medicare Advantage Plan when you first become eligible for Medicare, during your Initial Enrollment Period, which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B, or during the annual enrollment period, and in certain special situations that provide a special enrollment period.
- You can only join one Medicare Advantage Plan at a time, and enrollment in a plan is generally for a calendar year.
- You can switch to another Medicare Advantage Plan or to Original Medicare during the annual enrollment period from October 15 December 7.



See Section 3204 of the Affordable Care Act.

When You Can Drop an MA Plan Medicare Between January 1–February 14 Advantage You can leave an MA plan Disenrollment Go back to Original Medicare Period -Coverage begins the first of the month New in 2011 after you leave MA plan ■ If you make this change, you also may join a Part D Plan to add drug coverage Drug coverage begins first of the month after the plan gets enrollment form Cannot join another MA plan during this period 04/28/2011 **Understanding Medicare** 58

- New: If you belong to an MA plan, you can switch to Original Medicare from January 1 February 14. If you go back to Original Medicare during this time, coverage under Original Medicare will take effect on the first day of the calendar month following the date on which the election or change was made.
- To disenroll from an MA plan and return to Original Medicare during this period, you can
 - Make a request directly to the MA organization
 - Call 1-800-MEDICARE
 - Enroll in a stand alone PDP
- If you make this change you may also join a Medicare Prescription Drug Plan to add drug coverage. Coverage begins the first of the month after the plan receives the enrollment form.

NOTE: See Appendix B for a job aid on the Medicare Advantage Disenrollment Period.



See Section 3204 of the Affordable Care Act.

Medicare Advantage Plan Costs

- Must still pay Part B premium
 - Some plans may pay all or part for you
 - Some people may be eligible for state assistance
- You may also pay monthly premium to plan
- You pay deductibles/coinsurance/copayments
 - Different from Original Medicare
 - Varies from plan to plan

04/28/2011

Understanding Medicare

- If you join a Medicare Advantage Plan you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2011 is \$115.40 (\$96.40 or \$110.50 in 2011 for most people).
 - Some plans may pay all or part for you
 - Some people may be eligible for state assistance
- You may pay an additional monthly premium to plan
- You pay deductibles, coinsurance and copayments
 - Different from Original Medicare
 - Varies from plan to plan

Other Types of Medicare Plans

- Other types of Medicare health plans
 - Not Medicare Advantage Plans
 - Medicare Cost Plans
 - Demonstrations and Pilot Programs
 - Programs of All-inclusive Care for the Elderly (PACE)

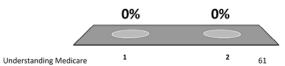
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Only available in certain areas

- There are three other types of other Medicare health plans that are not Medicare Advantage Plans. These plan types are available only in limited areas.
 - Medicare Cost Plans—similar to an HMO, but services received outside the plan are covered under Original Medicare.
 - Demonstrations and pilot programs—special projects that test possible future improvements in Medicare coverage, costs, and quality of care.
 - PACE (Programs of All-inclusive Care for the Elderly)—combines medical, social, and long-term care services for frail elderly people, those who are eligible for both Medicare and Medicaid.

Exercise

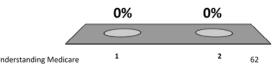
- A. Programs of All-inclusive Care for the Elderly (PACE) is a type of Medicare Advantage Plan.
 - 1. True
 - 2. False



04/28/2011

Exercise

- B. The Medicare Advantage Disenrollment Period is from January 1 through February 14.
 - 1. True
 - 2. False



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Medicare Prescription Drug Coverage

- What it is
- Enrollment
- Joining and switching plans
- Costs
- Extra Help
- Coverage
- How plans work

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Understanding Medicare

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Medicare Prescription Drug Coverage explains the following:

- What it is
- Enrollment
- Joining and switching plans
- Costs
- Extra Help
- Coverage
- How plans work

Medicare Prescription Drug Coverage

- Also called Medicare Part D or PDPs
- Available for all people with Medicare
- Provided through
 - Medicare Prescription Drug Plans
 - Medicare Advantage Plans
 - Other Medicare plans
- Must include range of drugs in each category

04/28/2011

Understanding Medicare

- Everyone with Medicare can join a Medicare prescription drug plan to help lower prescription drug costs and help protect against higher costs in the future.
- Medicare contracts with private companies that offer prescription drug plans to negotiate discounted prices on behalf of their enrollees.
- People with Medicare can also receive drug benefits through a Medicare Advantage Plan or other Medicare plan if they are enrolled in one. (Some employers and unions may also provide Medicare drug coverage to people with Medicare.)
- The drug lists (formulary) for each plan must include a range of drugs in each prescribed category. This makes sure that people with different medical conditions can get the treatment they need. All Medicare drug plans generally must cover at least two drugs in each category of drugs, but plans can choose which specific drugs are covered in each category.

Enrollment in Part D

- You must have Medicare Part A and/or Part B
- You must live in the plan's service area
- You can't live outside the U.S.
- You can't be incarcerated
- You must enroll in a Medicare Part D plan
 - In most cases no automatic enrollment
 - You must fill out an application

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Understanding Medicare

- Anyone who has Medicare Part A (hospital insurance) and/or Part B (medical insurance) is eligible to join a Medicare prescription drug plan. You must live in the service area of a plan to enroll in it.
- Individuals who live outside of the U.S. or who are incarcerated cannot enroll in a Medicare drug plan.
- In most cases, you must enroll in a Medicare drug plan to get Medicare prescription drug coverage. In most cases, you must fill out an application and enroll with a plan to get coverage. However, if people who are found eligible for Extra Help do not choose a plan on their own, CMS will usually enroll them in one.

| When you can Join or Switch Medicare Prescription Drug Plans | | | | | |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--|--|--|
| Initial Enrollment Period (IEP) | 7 month periodStarts 3 months before month of elig | ibility | | | |
| Annual Enrollment Period | October 15 – December 7 each year These are new dates | New in 2011 | | | |
| Annual Medicare Advantage Disenrollment Period New in 2011 | Between January 1–February 14, you can leave an MA plan and switch to Original Medicare. If you make this change, you ma also join a Part D plan to add drug coverage Coverage begins the first of the month afte the plan gets the enrollment form. | | | | |
| 04/28/2011 | Understanding Medicare | 66 | | | |

- You can join a Medicare Prescription Drug Plan when you first become eligible for Medicare, i.e., during your initial enrollment period, which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B. After you enroll in a Medicare Prescription Drug Plan you must remain with that plan for the rest of the calendar year.
- You can also enroll in a Medicare Part D plan during the annual enrollment period (also known as open enrollment), October 15 – December 7 each year. You can also change Medicare Part D plans during the annual enrollment period.
- There is a new annual disenrollment period that started in 2011. Between January 1— February 14, you can leave an MA plan and switch to Original Medicare. If you make this change, you may also join a Medicare Part D plan to add drug coverage. Coverage begins the first of the month after the plan receives the enrollment form.

NOTE: See Appendix B for a job aid on the Medicare Advantage Disenrollment Period.



See Section 3204 of the Affordable Care Act.

| Joining or Switching Part D Plans | | | | |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| Special Enrollment Periods (SEP) | Examples of when you get an SEP include You permanently move out of your plan's service area You lose other creditable Rx coverage You weren't adequately informed your other coverage was not creditable or was reduced and is no longer creditable You enter, live in or leave a long-term care facility You have a continuous SEP if you qualify for Extra Help | | | |
| 04/28/2011 | Understanding Medicare 67 | | | |

- In certain situations, you may get a special enrollment period (SEP). The following are examples of when you would get an SEP.
 - If you permanently move out of your plan's service area
 - If you lose your other creditable prescription drug coverage
 - If you were not adequately informed that your other coverage was not creditable, or that the coverage was reduced so that it is no longer creditable
 - When you enter, reside in, or leave a long-term care facility like a nursing home
 - If you qualify for Extra Help, you have a continuous special enrollment period and can change your Medicare prescription drug plan at any time
 - Or in exceptional circumstances, such as if you no longer qualify for Extra Help

Medicare Prescription Drug Coverage

- Must cover all drugs in 6 classes
 - Anti-psychotics
 - Anti-depressants
 - Anti-convulsants
 - Immunosuppressants
 - Cancer Drugs
 - HIV/AIDS Drugs

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Understanding Medicare

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Plans are required to cover all drugs in six classes: anti-psychotics, anti-depressants, anti-convulsants, immunosuppressants, cancer, and HIV/AIDS drugs.

Prescription Drug Costs

- Costs vary by plan
- In 2011 most people will pay
 - A monthly premium
 - An annual deductible
 - Copayments or coinsurance



- 50% on covered brand-name drugs in donut hole
- 7% on generic drugs in donut hole
- Very little after spending \$4,550 out-of-pocket

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- Costs vary depending on the plan. Most people will pay a monthly premium for Medicare prescription drug coverage. You will also pay a share of the cost of your prescriptions, including a deductible, copayments, and/or coinsurance. All Medicare drug plans have to provide at least a standard level of coverage, set by Medicare. However, some plans might offer more coverage and additional drugs, generally for a higher monthly premium. With every plan, once you have paid \$4,550 out of pocket for drugs costs in 2011, you will pay 5% (or a small copayment) for each drug for the rest of the year.
- People with limited income and resources may be able to get Extra Help paying for their Medicare drug plan costs.
- The Affordable Care Act includes benefits to make your Medicare prescription drug coverage (Part D) more affordable. Starting January 1, 2011, if you reach the coverage gap, (also known as the "donut hole") in your Medicare prescription drug coverage, you will get the following:
 - A 50% discount on covered brand-name drugs when you buy them at a pharmacy or order them through the mail.
 - Some coverage for generic drugs (7% discount). You can expect additional savings on your brand-name and generic drugs during the coverage gap over the next 10 years until it's closed in 2020.

NOTE: See Appendix C for a chart of standard coverage and Low Income Subsidy copays.

Part D Coverage Gap



- If you reach the coverage gap in 2011
 - You get a 50% discount on brand-name Rx drugs
 - You get a 7% discount for generic drugs
 - Entire price counts toward catastrophic coverage
 - Dispensing fees not discounted
- Additional savings in coverage gap each year
- Gap to be closed in 2020

04/28/2011 Understanding Medicare 70

- Most Medicare drug plans have a coverage gap. This means that after you and your plan have spent \$310 for covered drugs, you have to pay 25% of the cost of your prescriptions until the total cost of all the medicine you have received in a year reaches \$2,830.
- Then, you are responsible for 100% of the out-of-pocket bill for your drugs until the total out-of-pocket cost of your medicines reaches \$4,550. This is called the coverage gap.
- If you reach the coverage gap in 2011, you may get a 50% discount on your brand-name prescription drugs at the time you buy them. You will also get a 7% discount on generic drugs. With this discount, you will only pay 50% of the price for the brand-name drug, but the entire price (including the 50% discount the drug company pays) will count toward the amount you need to qualify for catastrophic coverage.
- Dispensing fees are not discounted.



See Section 3315 of the Affordable Care Act.



For more information about how the Part D Coverage Gap is closing, see *Information Partners Can Use on Closing the Coverage Gap*, CMS Product No. 11495-P.

Medicare Prescription Drug Coverage Premium

- Higher income pay higher Part D premium
 - Uses same thresholds used to compute incomerelated adjustments to the Part B premium
 - As reported on your IRS tax return from 2 years ago
- Must pay if you have Part D coverage
- Effective January 2011



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- Reducing Part D Premium Subsidy for High-Income Beneficiaries Starting in January 2011, this provision adjusts Part D premiums (i.e., reduces government premium contribution) for high-income beneficiaries on a sliding scale. The income thresholds and corresponding percentage reductions in government premium contributions are the same as those in the Part B income-related premium adjustment. CMS is directed to provide information annually to the Social Security Administration (SSA) on the national Part D base beneficiary premium to calculate premium adjustment amount as well as data on the threshold amounts. SSA will identify beneficiaries that are subject to the premium adjustment based on income data received from the Internal Revenue Service and will deduct this adjustment from beneficiary Social Security payments (i.e., premiums otherwise charged by Part D plans will not change as a result of this provision).
- If you do not have enough money in your Social Security benefit, you will be billed by either CMS or RRB to pay the amount each month. Therefore, some people will pay their plan each month for their monthly premium and will pay CMS or RRB each month for their IRMAA amount. (The Part D-IRMAA amount is paid directly to the government and not the plan.)
- Beneficiaries subject to the Part D-IRMAA must pay the extra amount in addition to their plan's monthly premium. This includes individuals who have Part D coverage through an employer (but not through RDS or other creditable coverage.)



See Section 3308 of the Affordable Care Act.

| | | ★ ACA |
|-----------------------------------|--------------------------|-------------------|
| Income-Related | Adjustment to Part | D Premium |
| If your Yearly Income in 2009 was | | In 2011 You Pay |
| File Individual Tax Return | File Joint Tax Return | |
| \$85,000 or below | \$170,000 or below | Base Premium (BP) |
| \$85,000.01 – \$107,000 | \$170,000.01 - \$214,000 | BP + \$12.00 |
| \$107,000.01 - \$160,000 | \$214,000.01 - \$320,000 | BP + \$31.10 |
| \$160,000.01 - \$214,000 | \$320,000.01 - \$428,000 | BP + \$50.10 |
| \$214,000.01 or higher | \$428,000.01 or higher | BP + \$69.10 |
| | | |
| | | |
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- IRMAA stands for Income-Related Monthly Adjustment Amount.
- If your yearly income in 2009 was 85K or less for an individual or \$170K or less for a couple, you pay the base premium.
- You pay a higher amount, based on your yearly income, if your yearly income in 2009 was higher than 85K for an individual or \$170K for a couple. The amount of the IRMAA is adjusted each year, as it is calculated from the annual beneficiary base premium.



For information on how the Part B income-related premium is determined, see SSA Pub. 10161 at http://www.socialsecurity.gov/pubs/10536.pdf.



See Section 3308 of the Affordable Care Act.

Part D Late Enrollment Penalty

- Higher premium for some who wait to enroll
 - After first eligible without creditable drug coverage
 - Additional 1% of base beneficiary premium
 - Every month eligible and not enrolled
 - For as long as they have Medicare drug coverage
 - No penalty with creditable drug coverage
 - Coverage at least as good as Medicare drug coverage

- If you choose to not join a Medicare prescription drug plan at your first opportunity, you may have to pay a higher monthly premium (penalty) if you decide to enroll later.
- The penalty is added to the premium payment amount. It is calculated by multiplying 1% of the national base beneficiary premium by the number of months the person was eligible but not enrolled in a plan and did not have creditable drug coverage. The penalty calculation is not based on the premium of the plan the individual is enrolled in. The base beneficiary premium (\$32.34 in 2011) is a national number and can change each year. (Note: In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium. The base member premium is different from the average beneficiary premium. The average member premium reflects the specific plan-by-plan premiums and the actual number of people who are enrolled in each plan.)
- People who have another source of drug coverage—through a former employer, for example—may choose to stay in that plan and not enroll in a Medicare prescription drug plan. If your other coverage is at least as good as Medicare prescription drug coverage, called "creditable" coverage, you will not have to pay a higher premium if you later join a Medicare prescription drug plan. Your other plan will notify you about whether or not your coverage is creditable. This notice will explain your options. You can contact your plan's benefits administrator for more information.
- Some examples of coverage that may be considered creditable include
 - Group Health Plans (GHPs)
 - State Pharmaceutical Assistance Programs (SPAPs)
 - VA coverage and Military coverage including TRICARE
- If you don't agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You will need to fill out a reconsideration request form (that your Medicare drug plan will send you), and you will have the chance to provide proof that supports your case such as information about previous prescription drug coverage. If you need help, call your Medicare drug plan.

Extra Help with Drug Plan Costs

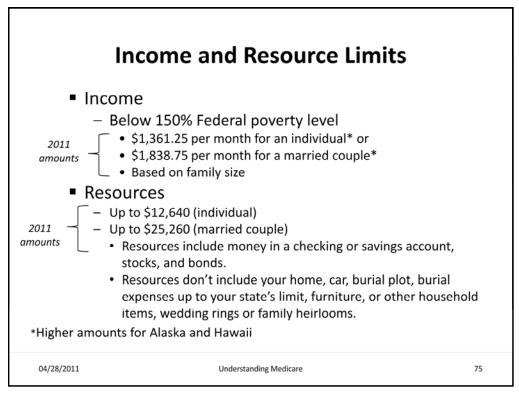
- Help for people with limited income and resources
- Social Security or state makes determination
- Some groups automatically qualify
 - People with Medicare and Medicaid
 - Supplemental Security Income (SSI) only
 - Medicare Savings Programs
- Everyone else must apply

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- People with Medicare who have limited incomes and resources may be able to get Extra Help with the costs of Medicare prescription drug coverage. You must be enrolled in a Medicare prescription drug plan to get Extra Help.
- You can apply with either Social Security or your state's Medicaid program office. When you apply, you will be asked for information about your income and resources, and you will be asked to sign a statement that your answers are true. Social Security will check your information from computer records at the Internal Revenue Service and other sources. You may be contacted if more information is needed.
- When your application has been processed, you will get a letter telling you if you qualify for Extra Help.
- Certain groups of people automatically qualify for Extra Help and do not have to apply. These include:
 - People with Medicare and full Medicaid benefits (including prescription drug coverage)
 - People with Medicare who get Supplemental Security Income only (SSI)
 - People who get help from Medicaid paying their Medicare premiums (Medicare Savings Programs)
- All other people with Medicare must file an application to get Extra Help.



- Extra Help is available to people with Medicare with income below 150% of the Federal poverty level and limited resources.
- Medicare counts the income of you and your spouse (living in the same household), regardless of whether or not your spouse is applying for Extra Help. The income is compared to the Federal poverty level for a single person or a married person, as appropriate. This takes into consideration whether you and/or your spouse has dependent relatives who live with you and who rely on you for at least half of their support. A grandparent raising grandchildren may qualify, but the same person might not have qualified as an individual living alone.
- Resources also are counted for you and a spouse (living with you).
 - Resources include money in a checking or savings account, stocks, and bonds. Resources don't
 include your home, car, burial plot, burial expenses up to your state's limit, furniture, or other
 household items, wedding rings or family heirlooms.

NOTE: Extra Help isn't available to people in the U.S. territories. The territories have their own rules for providing help with Medicare drug plan costs to their residents.

Applying for Extra Help

- Multiple ways to apply
 - Fill out a paper application
 - On the web at socialsecurity.gov
 - Through your State Medical Assistance office
 - Through a local organization
- You or someone on your behalf can apply

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- Eligibility for Extra Help may be determined by either Social Security or your state
 Medicaid office.
- You can apply for Extra Help by
 - Completing a paper application that you can get by calling Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778)
 - Applying with Social Security at www.socialsecurity.gov on the Web
 - Applying through your state Medical Assistance office
 - Working with a local organization, such as your State Health Insurance Assistance Program (SHIP)
- You can apply on your own behalf, or your application can be filed by a personal representative with the authority to act on your behalf, such as Power of Attorney, or you can ask someone else to help you apply.



Under Section 113 of MIPPA, Social Security is directed to transmit data from the LIS application, with the consent of the applicant, to the Medicaid agency for purposes of initiating an application for Medicare Savings Programs (MSP). The states are directed to treat the data as an application for MSP benefits, as if it had been submitted directly by the applicant.

Access to Covered Drugs

- Coverage and rules vary by plan
- Plans manage access to drug coverage
 - Formularies (list of covered drugs)
 - Prior authorization (doctor contacts plan)
 - Step therapy (type of prior authorization)
 - Quantity limits (limits quantity for period of time)

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- Coverage and rules vary by plan, which can affect what a member pays.
- There are a variety of methods (rules) plans use to manage their members' access to drug coverage include the following:
 - Formularies (list of covered drugs)
 - Prior authorization (doctor contacts the plan to explain why this drug is medically-necessary)
 - Step therapy (type of prior authorization)
 - Quantity limits (limits quantity for period of time)

Formulary

- A list of prescription drugs covered by the plan
- May have "tiers" that cost different amounts

Example of Tiers (Plans can form tiers in different ways) Prescription Tier You Pay **Drugs Covered** 1 Lowest copayment Most generics Preferred, brand-name 2 Medium copayment 3 Highest copayment Non-preferred, brand-name Highest copayment or Unique, very high-cost Specialty coinsurance 04/28/2011 Understanding Medicare 78

- Each Medicare drug plan has a list of prescription drugs that it covers called a formulary.
 - Plans cover both generic and brand-name prescription drugs.
 - Using drugs on your plan's list and using generics instead of brand-name drugs can both save you money.
- Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different "tiers," which cost different amounts. Each plan can form its tiers in different ways.
- Here is an example of how a plan might form its tiers:
 - Tier 1–Generic drug (costs the least amount) Generic drugs are the same as a brandname drug in active ingredients, dosage, safety, strength, how it is taken, how it works in the body, quality, performance and intended use. They are safe and effective, and have the same risks and benefits as the original brand-name drug. Generic drugs are less expensive because of market competition. Generic drugs are thoroughly tested and must be approved by the FDA.
 - Tier 2-Preferred brand-name drugs. Tier 2 drugs will cost more than Tier 1 drugs.
 - Tier 3-Non-preferred brand-name drugs. Tier 3 drugs will cost more than Tier 2 drugs.
 - Specialty Tier These drugs are unique and have a high cost.

NOTE: In some cases, if your drug is in a higher (more expensive) tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can file an exception and ask your plan for a lower copayment.

Prior Authorization

- Doctor must contact plan
 - Must show medical necessity for specific drug
- Ask plan for prior authorization requirements
 - Process for requests may vary by plan

- Plans may have rules that require prior authorization. Prior authorization means that before the plan will cover a prescription, your doctor must first contact the plan. The doctor has to show there is a medically-necessary reason why you must use that particular drug for it to be covered. Plans do this to be sure these drugs are used correctly and only when medically necessary.
- Current or prospective plan members or their representatives can request the plan's prior authorization requirements in order to understand what they will need to do to access a drug or to provide this information to their doctors. Prior authorization requirements are also available on Part D plans' (sponsors') websites.

Step Therapy

- A type of prior authorization
 - First try similar less expensive drug
 - · Proven effective for most people
- Doctor can request an exception
 - Similar, less expensive, drug didn't work or
 - Step-therapy drug is medically necessary

- Step therapy is a type of prior authorization. With step therapy, in most cases you must first try less expensive drugs that have been proven effective for most people with a specific medical condition. For example, some plans may require members to try a generic drug (if available), then a less expensive brand-name drug on their drug list before they will cover a more expensive brand-name drug.
- However, if you have already tried a similar, less expensive drug that didn't work, or if the doctor believes that because of your medical condition it is medically necessary to take a step-therapy drug (the drug the doctor originally prescribed), the member, their representative (with the doctor's help), or the prescriber can contact the plan to request an exception (doctor's supporting statement required). If the request is approved, the originally prescribed step-therapy drug will be covered.

| | Example of Step Therapy |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Step 1 | Dr. Smith wants to prescribe a new sleeping pill to treat Mr. Mason's occasional insomnia. There's more than one type of sleeping pill available. Some of the drugs Dr. Smith considers prescribing are brand-name only prescription drugs. The plan rules require Mr. Mason to try the generic prescription drug zolpidem first. For most people, zolpidem works as well as brand-name prescription drugs. |
| Step 2 | If Mr. Mason takes zolpidem but has side effects, Dr. Smith can use that information to ask the plan to approve a brand-name drug. If approved, Mr. Mason's Medicare drug plan will cover the brandname drug for Mr. Mason. |
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Example of step therapy

- Step 1—Dr. Smith wants to prescribe a new sleeping pill to treat Mr. Mason's occasional insomnia. There's more than one type of sleeping pill available. Some of the drugs Dr. Smith considers prescribing are brand-name only prescription drugs. The plan rules require Mr. Mason to try the generic prescription drug zolpidem first. For most people, zolpidem works as well as brand-name prescription drugs.
- Step 2—If Mr. Mason takes zolpidem but has side effects, Dr. Smith can use that information to ask the plan to approve a brand-name drug. If approved, Mr. Mason's Medicare drug plan will cover the brand-name drug for Mr. Mason.

Quantity Limits

- Plans may limit how much medication you can get at a time
 - Over a certain period of time
 - For reasons of safety and/or cost
- Doctor may need to request an exception
 - If an additional amount is medically necessary

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- For safety and cost reasons, plans may limit how much medication you can get over a certain period of time.
- If you require more, then you, your representative, or the prescriber may need to contact the plan to request an exception if he/she believes the additional amount is medically necessary (doctor's supporting statement required). If the request is approved, the amount prescribed by the doctor will be covered.

Drugs Excluded by Law from Medicare Coverage

- Anorexia, weight loss or weight gain drugs
- Barbiturates and benzodiazepines*
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes (e.g., hair growth)
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
- Non-prescription drugs

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- These are drugs that are excluded by law from Medicare coverage
 - Anorexia, weight loss or weight gain drugs
 - Barbiturates and benzodiazepines
 - Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration
 - Fertility drugs
 - Drugs for cosmetic or lifestyle purposes (e.g., hair growth)
 - Drugs for symptomatic relief of coughs and colds
 - Prescription vitamin and mineral products (except prenatal vitamins and fluoride preparations)
 - Non-prescription drugs

NOTE: Benzodiazepines and barbiturates will be covered starting in 2013.

^{*}To be covered in 2013

Drugs Not Covered by Part D

- Medicare Part A or Part B covered drugs
 - Unless Part A or B coverage requirements not met
- Plan may choose to cover excluded drugs
 - At their own cost, or
 - Share the cost with members

- Part D can only cover Medicare Part A or Part B covered drugs if the person does not meet the Part A or Part B coverage requirements.
 - Drugs covered under Part B include immunosuppressive drugs after an organ transplant, some oral anti-cancer drugs, hemophilia clotting factors, and drugs that are not self-administered.
- Plans may choose to cover excluded drugs at their own cost or share the cost with their members.

Exercise

- A. Quantity limits are lifetime limits.
 - 1. False
 - 2. True

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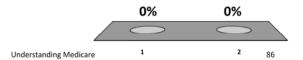
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Exercise

- B. Medicare determines who qualifies for Extra Help.
 - 1. True
 - 2. False



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Lesson 3 – Rights and the Appeals Process

- Patient Rights
- Appeals Process
 - Part A and B (Original Medicare)
 - Part C (Medicare Advantage)
 - Part D (Medicare Prescription Drug Coverage)

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Rights and the Appeals Process provides an overview of your Medicare rights and the process for appealing certain decisions.

- Part A and B (Original Medicare) appeals process
- Part C (Medicare Advantage) appeals process
- Part D (Medicare Prescription Drug Coverage) appeals process

Guaranteed Rights Under Medicare

- You have guaranteed rights in
 - Original Medicare
 - Medicare Advantage and other health plans
 - Medicare Prescription Drug Plans

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You have certain guaranteed rights under the Medicare program in Original Medicare, Medicare Advantage and other health plans, and Medicare prescription drug plans.

Medicare Rights

- Protect you when you get health care
- Ensure you get medically necessary, Medicarecovered health care services
- Protect you against unethical practices
- Protect your privacy

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■ These rights protect you when you get health care, ensure you get medically necessary Medicare-covered health care services, protect you against unethical practices, and protect your privacy.

You Have the Right to

- Be treated with dignity and respect
- Be protected from discrimination
- Get information you can understand
- Get culturally-competent services
- Get emergency care where and when you need it
- Get urgently needed care
- Get answers to your Medicare questions

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- You have the right to
 - Be treated with dignity and respect at all times
 - Be protected from discrimination
 - Get information about Medicare you can understand to make health care decisions
 - This includes information on what is covered, which costs are paid, how much you have to pay, and what to do to file a complaint
 - Get culturally-competent services in a language you can understand and in a culturally sensitive way
 - Get emergency care when and where you need it
 - Urgently needed care is care that you get for a sudden illness or injury that needs medical care right away, but is not a serious threat to your health.
 - Get your questions about Medicare answered



You can call 1-800-MEDICARE or contact your State Health Insurance Assistance Program. Their numbers are on www.medicare.gov and listed in the *Medicare & You* handbook, CMS Product No. 10050.



You Have the Right to

- Learn about your treatment choices
 - In clear understandable language
- File a complaint
- Appeal a denial of a treatment or payment
- Have personal information kept private
- Know your privacy rights

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- You also have the right to
 - Learn about treatment choices in clear, understandable language
 - Medicare health plans cannot prevent your doctor from telling you what you need to know about your treatment choices
 - File a complaint about payment, services, or other problems, including the quality of your health care
 - Appeal decisions about coverage and/or payment
 - Have the personal information that Medicare collects about you kept private
 - Know your privacy rights

Right to File a Complaint or Appeal

- Complaint (sometimes called a grievance)
 - Quality of services
 - Care that is received
- Appeal a coverage or payment decision
- For information contact
 - Your plan
 - Your State Health Insurance Assistance Program
 - 1-800-MEDICARE (1-800-633-4227)

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- You have the right to file a complaint about concerns or problems you may have had in getting health care or the quality of the health care received.
- An appeal is the action you should take if you disagree with a coverage or payment decision (i.e., Medicare should have paid but didn't, or didn't pay enough; a Medicare health plan denied a needed service; or a Part D plan didn't cover a prescription drug).



For more information on filing an appeal or complaint, call your plan, the State Health Insurance Assistance Program (SHIP) in your state, or 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Appeals in Original Medicare

- Ask provider for information to help your case
- Medicare Summary Notice explains appeal
 - Why Medicare didn't pay
 - How to appeal
 - Where to file your appeal
 - How long you have to appeal
- Keep copies of appeal documents

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- In Original Medicare, you can file an appeal if you think Medicare should have paid for an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. If you have received care and you aren't sure if Medicare was billed for the items or services that you got, write or call your doctor, health care provider, or supplier and ask for an itemized statement.
- Appeal instructions are on the Medicare Summary Notice (MSN) that is mailed to you by the company that handles your Medicare bills. The notice will also tell you why Medicare didn't pay your bill and how you can appeal. It will tell you where to file the appeal and the time limit for filing your appeal.
- You should keep a copy of everything you send to Medicare as part of your appeal.

Rights in Medicare Health Plans

- Choice of plan's health care providers
- Access to plan's specialists (treatment plan)
- Know how your doctors are paid
- Fair, efficient, and timely appeals process
 - Fast appeals in certain health care settings

- If you're in a Medicare health plan, in addition to the rights and protections previously described, you have the right to:
 - Choose health care providers in the plan so you can get covered health care.
 - Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.
 - Know how your doctors are paid if you ask your plan. Medicare doesn't allow a
 plan to pay doctors in a way that interferes with you getting needed care.
 - A fair, efficient, and timely appeals process to resolve payment and coverage disputes with your plan. You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued.

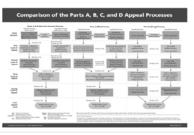
Rights in Medicare Health Plans

- Grievance process
- Coverage/payment information before service
- Privacy of personal health information
- Urgently needed care
- Contact your plan for more information

- If you're in a Medicare health plan, in addition to the rights and protections previously described, you have rights:
 - To file a grievance about other concerns or problems with your plan, e.g., if you
 believe your plan's hours of operation should be different, or there aren't enough
 specialists in the plan to meet your needs. Check your plan's membership
 materials or call your plan to find out how to file a grievance.
 - To get a coverage decision or coverage information from your plan before getting services to find out if it will be covered or to get information about your coverage rules. You can also call your plan if you have questions about home health care rights and protections. Your plan must tell you if you ask.
 - To privacy of personal health information. For more information about your rights to privacy, look in your plan materials, or call your plan.
 - To urgently needed care, which is the care that you get for a sudden illness or injury that needs medical care right away, but is not a serious threat to your health. If you are in a Medicare health plan, health care providers in the plan's network generally provide care if you are in the plan's service area. If you are out of your plan's service area for a short time (less than 6 months) and cannot wait until you return home, the health plan must pay for urgently needed care.
- For more information about your rights and protections, read your plan's membership materials or call your plan.

Parts A, B, C, and D Appeal Processes

- Your rights
 - Protect you when you get health care
 - Make sure you get the health care services that the law says you can get
 - Protect you against unethical practices
 - Protect your privacy
- See chart in Appendix D



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- No matter how you get your Medicare, you have certain rights and protections designed to do the following:
 - Protect you when you get health care
 - Make sure you get the health care services that the law says you can get
 - Protect you against unethical practices
 - Protect your privacy
- This chart shows the appeals process in Parts A, B, C, and D of Medicare.
- This chart is provided as a handout in the back of the corresponding workbook.



For more information about appeals, go to www.medicare.gov and view the publication *Your Medicare Rights and Protections*, CMS Product No. 10112.

Module 2 explains appeals in more detail.

NOTE: A full size copy of this chart is provided in the corresponding workbook. See Appendix D.

Rights in Medicare Health Plans

- Grievance process
- Coverage/payment information before service
- Privacy of personal health information

- If you're in a Medicare health plan, in addition to the rights and protections previously described, you have the right to:
 - File a grievance about other concerns or problems with your plan, e.g., if you
 believe your plan's hours of operation should be different, or there aren't enough
 specialists in the plan to meet your needs. Check your plan's membership
 materials or call your plan to find out how to file a grievance.
 - Get a coverage decision or coverage information from your plan before getting services to find out if it will be covered or to get information about your coverage rules. You can also call your plan if you have questions about home health care rights and protections. Your plan must tell you if you ask.
 - Privacy of personal health information. For more information about your rights to privacy, look in your plan materials, or call your plan.
 - For more about your rights and protections, read your plan's membership materials or call your plan.

Lesson 4 – Programs for People with Limited Income and Resources • Medicaid • Medicare Savings Programs • Help available for people in the U.S. territories

- Lesson 4 Programs for People with Limited Income and Resources explains
 - Medicaid
 - Medicare Savings Programs
 - Help available for people who live in the U.S. territories

NOTE: Information on Extra Help paying Medicare prescription drug costs is on slides 74-76.

Medicaid

- Federal-state health insurance program
 - For people with limited income and resources
 - Certain people with disabilities
- Most costs covered for Medicare/Medicaid
 - Called "dually eligible"
- Eligibility determined by state
- Application processes and benefits vary
- Office names vary

- Medicaid is a program that helps pay medical costs for some people with limited income and resources. Medicaid is jointly funded by the Federal and state government and is administered by each state. It can cover children; aged, blind, and disabled people; and some other groups, depending on the state. If you are eligible for both Medicare and Medicaid, most of your health care costs are covered; we often refer to these people as "dually eligible." People with both Medicare and Medicaid get drug coverage from Medicare, not Medicaid. People with Medicaid may get coverage for services that aren't fully covered by Medicare, such as nursing home care and home health care.
- Medicaid eligibility is determined by each state, and Medicaid application processes and benefits vary from state to state. You need to contact your state Medical Assistance office to see if you qualify. For instance, a person in Name of State, would apply for Medicaid at Name of Agency. [Instructor: insert information specific to Medicaid in your state.]

Medicare Savings Programs

- Help from Medicaid paying Medicare costs
 - For people with limited income and resources
 - Programs include
 - Qualified Medicare Beneficiary (QMB)
 - Specified Low-income Medicare Beneficiary (SLMB)
 - Qualifying Individual (QI)
 - Qualified Disabled & working Individuals (QDWI)
- See Appendix E

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- States have other programs that pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance for people with limited income and resources. These programs frequently have higher income and resource guidelines than Medicaid. These programs are collectively called Medicare Savings Programs, and include the Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs. See Appendix E for a chart with more detailed information on these programs.
- Eligibility for these programs is determined by income and resource levels. The income amounts are updated annually with the Federal poverty level.
- Additionally, some states offer their own programs to help people with Medicare pay the out-of-pocket costs of health care, including State Pharmacy Assistance Programs.



Under Section 113 of MIPPA, Social Security is directed to transmit data from the LIS application, with the consent of the applicant, to the Medicaid agency for purposes of initiating an application for Medicare Savings Programs (MSP). The state is directed to treat the data as an application for MSP benefits, as if it had been submitted directly by the applicant.





Contact your State Health Insurance Assistance Program (SHIP) to find out which programs may be available to you. You can find the contact information for your local SHIP by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Steps to Take

- If you think you might qualify
 - 1. Review guidelines
 - 2. Collect your personal documents
 - 3. Get more information
 - Call your state Medical Assistance office
 - Call your local SHIP
 - Call your local Area Agency on Aging
 - 4. Complete application with state Medical Assistance office

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- Here are some steps you can take to find out if you qualify for help with your Medicare out-of-pocket expenses.
- First, review the income and resource (or asset) guidelines for your area.
- If you think you may qualify, collect the personal documents the agency requires for the application process. You will need
 - Your Medicare card
 - Proof of identity
 - Proof of residence
 - Proof of any income, including pension checks, Social Security payments, etc.
 - Recent bank statements
 - Property deeds
 - Insurance policies
 - Financial statements for bonds or stocks
 - Proof of funeral or burial policies
- You can get more information by contacting your state Medical Assistance office, your local SHIP program, or your local Area Agency on Aging.
- Finally, complete an application with your state Medical Assistance office.

Programs in U.S. Territories

- Help people pay their Medicare costs
- U.S. territories
 - Puerto Rico
 - Virgin Islands
 - Guam
 - Northern Mariana Islands
 - American Samoa
- Programs vary
 - Contact Medical Assistance office

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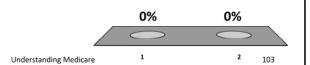
■ There are also programs available to help people with limited income and resources who live in the U.S. territories—Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa—pay their Medicare costs. Programs vary in these areas. Contact the Medical Assistance office in the territory for more information.

NOTE to instructor: If you none of these territories is in your area, you may wish to hide this slide.

Exercise

- A. Medicare Savings Programs frequently have higher income and resource limits than Medicaid.
 - 1. True
 - 2. False

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| Introduction to Medicare Resource Guide | Medicare Products | CMS Product No. 10050) Your Medicare Benefits CMS Product No. 10116 CMS Product No. 10116 CMS Product No. 10110 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare CMS Product No. 02110 To access these products View and order single copies at www.medicare.gov Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization. | |
|-----------------------------------------|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| | Resources | *For telephone numbers call CMS 1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users http://www.medicare.gov/caregivers/ http://www.healthCare.gov http://www.Benefits.gov http://www.Insurekidsnow.gov Affordable Care Act www.healthcare.gov/center/authoriti es/patient protection affordable car e act as passed.pdf | |
| | Resc | Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) www.medicare.gov www.CMS.gov TTY 1-800-325-0778 http://www.socialsecurity.gov/ Railroad Retirement Board 1-877-772-5772 http://www.rrb.gov/ | |

| | | | | | Me | digap | Medigap Plans | | | |
|-------------------------------------------------|-------|---|---|---|----|-------------|---------------|-----|-----|---|
| Medigap Benefits | ٧ | В | C | D | * | 9 | *** | **1 | Σ | z |
| Part A Coinsurance | > | > | > | ^ | ^ | ^ | > | > | > | > |
| Up to 365 Days | > | > | > | > | > | ^ | > | > | ^ | > |
| Part B Coinsurance | > | > | > | > | > | > | > | > | > | > |
| Blood | > | > | > | ~ | ^ | ^ | > | > | > | > |
| Hospice Care Coinsurance | > | > | > | > | > | > | > | > | > | > |
| Skilled Nursing Coinsurance | | | > | > | > | > | 20% | 75% | > | > |
| Part A Deductible | | > | > | > | ^ | ~ | 20% | 75% | 20% | > |
| Part B Deductible | | | > | | ^ | | | | | |
| Part B Excess Charges | | | | | > | > | | | | |
| Foreign Travel Emergency (Up to Plan Limits) | | | > | > | > | > | | | > | > |
| | :10:0 | ! | | | | | | | | |

^{*}Plan F has a high-deductible option. ** Plans K and L have out-of-pocket limits of \$4,640 and \$2,320 respectively

GUIDE TO THE MEDICARE ADVANTAGE DISENROLLMENT PERIOD (MADP)

January 1 – February 14

Original Medicare (OM) only



NO enrollment changes ALLOWED

OM & Prescription Drug Plan (PDP)



NO enrollment changes ALLOWED

MA only PFFS & PDP

You may switch to:



OM & same PDP or Cost Plan (with no PDP) & PDP

You may **NOT** switch to:



MA-PD or MA only or OM & new PDP

Medicare Advantage (MA) only

You may switch to:



OM only or
OM & PDP or
Cost Plan or
Cost Plan (with no PDP) & PDP

You may **NOT** switch to:



MA-PD or MA only

Medicare Advantage (MA) & Prescription Drug (PD)

You **may** switch to:



OM only or OM & PDP or Cost Plan or Cost Plan (with no PDP) & PDP

You may **NOT** switch to:



MA-PD or MA only

PART D BENEFIT PARAMETERS

| Part D Benefit Parameters | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---------------------------------------------------------------------|------------|------------|-----------------------------------------|------------|------------|-----------------------------------------|
| Standard Benefit Design Parameters | | | | | | |
| Deductible | \$250.00 | \$265.00 | \$275.00 | \$295.00 | \$310.00 | \$310.00 |
| Initial Coverage Limit | \$2,250.00 | \$2,400.00 | \$2,510.00 | \$2,700.00 | \$2,830.00 | \$2,840.00 |
| Out-of-Pocket Threshold | \$3,600.00 | \$3,850.00 | \$4,050.00 | \$4,350.00 | \$4,550.00 | \$4,550.00 |
| Total Covered Part D Drug Spend at OOP Threshold (2) | \$5,100.00 | \$5,451.25 | \$5,726.25 | \$6,153.75 | \$6,440.00 | \$6,447.50 |
| Minimum Cost-sharing in Catastrophic Coverage | , | | | | | , |
| Generic/Preferred multi-source drug | \$2.00 | \$2.15 | \$2.25 | \$2.40 | \$2.50 | \$2.50 |
| Other | \$5.00 | \$5.35 | \$5.60 | \$6.00 | \$6.30 | \$6.30 |
| Part D Full Benefit Dual Eligible Parameters | ,,,,,,, | , | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , | , | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| Copayments for Institutionalized Beneficiaries | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| Maximum Copayments for non-institutionalized Benes | , | , | , | , | , | , |
| Up to or at 100% FPL | | | | | | |
| Up to Out-of-Pocket Threshold (1) | | | | | | |
| Generic/Preferred multi-source drug | \$1.00 | \$1.00 | \$1.05 | \$1.10 | \$1.10 | \$1.10 |
| Other | \$3.00 | \$3.10 | \$3.10 | \$3.20 | \$3.30 | \$3.30 |
| Above Out-of-Pocket Threshold | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | |
| Over 100% FPL | , | , | , | , | , | |
| Up to Out-of-Pocket Threshold | | | | | | |
| Generic/Preferred multi-source drug | \$2.00 | \$2.15 | \$2.25 | \$2.40 | \$2.50 | \$2.50 |
| Others | \$5.00 | \$5.35 | \$5.60 | \$6.00 | \$6.30 | \$6.30 |
| Above Out-of-Pocket Threshold | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| Part D Non-Full Benefit Dual Eligible | | · | | · | | - |
| Full Subsidy Parameters | | | | | | |
| Resources (1) | | | | | | |
| Maximum Copayments up to Out-of-Pocket Threshold | | | | | | |
| Generic/Preferred multi-source drug | \$2.00 | \$2.15 | \$2.25 | \$2.40 | \$2.50 | \$2.50 |
| Other | \$5.00 | \$5.35 | \$5.60 | \$6.00 | \$6.30 | \$6.30 |
| Above Out-of-Pocket Threshold | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| Resources (2) | | | | | | |
| Deductible | \$50.00 | \$53.00 | \$56.00 | \$60.00 | \$63.00 | \$63.00 |
| Coinsurance up to Out-of-Pocket Threshold | 15% | 15% | 15% | 15% | 15% | 15% |
| Maximum Copayments above Out-of-Pocket Threshold | | | | | | |
| Generic/Preferred multi-source drug | \$2.00 | \$2.15 | \$2.25 | \$2.40 | \$2.50 | \$2.50 |
| Others | \$5.00 | \$5.35 | \$5.60 | \$6.00 | \$6.30 | \$6.30 |
| Part D Non-Full Benefit Dual Eligible Partial Subsidy Parameters | | | | | | |
| Deductible | \$50.00 | \$53.00 | \$56.00 | \$60.00 | \$63.00 | \$63.00 |
| Coinsurance up to Out-of-Pocket Threshold | 15% | 15% | 15% | 15% | 15% | 15% |
| Maximum Copyments above Out-of-Pocket Threshold | | | | | | |
| Generic/Preferred multi-source drug | \$2.00 | \$2.15 | \$2.25 | \$2.40 | \$2.50 | \$2.50 |
| Other | \$5.00 | \$5.35 | \$5.60 | \$6.00 | \$6.30 | \$6.30 |
| Retiree Drug Subsidy Amounts | | | | | | |
| Cost Threshold | \$250.00 | \$265.00 | \$275.00 | \$295.00 | \$310.00 | \$310.00 |
| Cost Limit | \$5,000.00 | \$5,350.00 | \$5,600.00 | \$6,000.00 | \$6,300.00 | \$6,300.00 |

Resources (1)

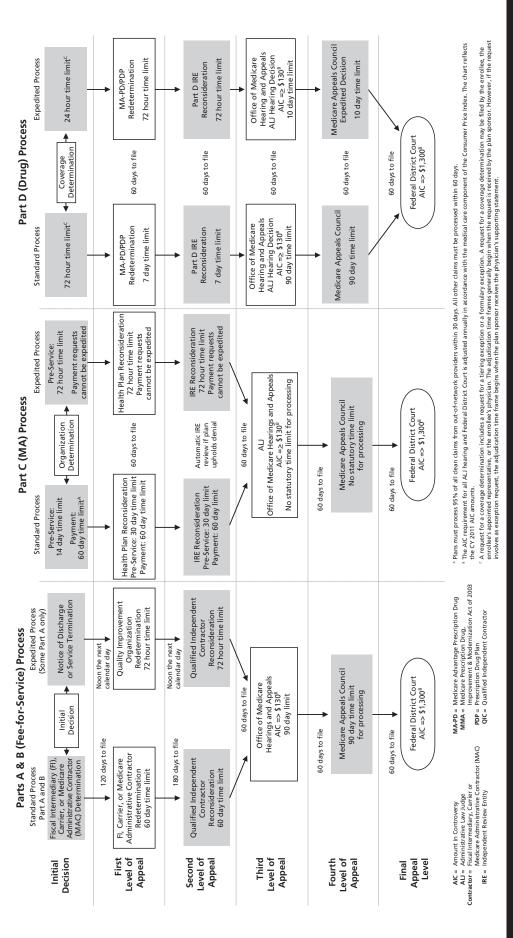
2006 Resources \leq \$6,000 (individuals) or \leq \$9,000 (couples) 2007 Resources \leq \$6,120 (individuals) or \leq \$9,190 (couples)

2008 Resources \leq \$6,120 (individuals) or \leq \$9,190 (couples) 2009 Resources \leq \$8,100 (individuals) or \leq 12,910 (couples)

2010 Resources \leq \$8,100 (individual) or \leq \$12,910 (couples)

Resources (2)

2006 Res. Bet. \$6,000-\$10,000 (ind) or \$9,000-\$20,000 (couples) 2007 Res. Bet. \$6,120-\$10,210 (ind) or \$9,190-\$20,410 (couples) 2008 Res. Bet. \$6,120-\$10,210 (ind) or \$9,190-\$20,410 (couples) 2009 Res Bet. \$8,100-\$12,510 (ind) or \$12,910-\$25,010 (couples) 2010 Res Bet. \$8,100-\$12,510 (ind) or \$12,910-\$25,010 (couples)



Comparison of the Parts A, B, C, and D Appeal Processes

Revised April 2011

Medicare Savings Programs

premiums. States have programs that can help pay your Medicare expenses (like premiums, deductibles, and coinsurance). You must You may qualify to get help paying for your Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) have Medicare Part A (Hospital Insurance) to qualify for a Medicare Savings Program If you qualify for QMB, SLMB, or QI, you automatically qualify for "Extra Help" paying the costs of Medicare prescription drug coverage.

| Medicare Savings Program | Individual | Married Couple | Helps Pay Your |
|----------------------------|---------------|----------------|---------------------------------------------------|
| | Monthly | Monthly Income | |
| | Income Limit* | Limit* | |
| Qualified Medicare | \$928 | \$1,246 | Part A and part B premiums, and other cost-sharin |
| Beneficiary (QMB) | | | (like deductibles, coinsurance, and copayments) |
| Specified Low-Income | \$1,109 | \$1,491 | Part B premiums only |
| Medicare Beneficiary | | | |
| (SLMB) | | | |
| Qualifying Individual (QI) | \$1,246 | \$1,675 | Part B premiums only |
| Qualified Disabled & | \$3,715 | \$4,989 | Part A premiums only |
| Working Individuals | | | |
| (QDWI) | | | |

slightly higher in Alaska and Hawaii. Some states have higher resource levels or don't count resources. Check with your state to find out figure your income and resources differently, so you may be eligible in your state even if you think you exceed these limits. Limits are * If you have income from working, you may qualify for these benefits even if your income is higher than these limits. Many states more.

It's very important to call or fill out an application if you think you could qualify for savings, even if your income or resources are higher than the amounts listed above. Call your Medicaid office to find out if you qualify. Call 1-800-MEDICARE (1-800-633-4227) to get their phone number. TTY users should call 1-877-486-2048. Or, visit www.medicare.gov/contacts.



E-mail: NMTP@cms.hhs.gov
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